University of Massachusetts Amherst
ScholarWorks@UMass Amherst

Doctoral Dissertations 1896 - February 2014

1-1-1977

Application of labelling theory to the problems of mental illness.

Irvin D. Rhodes
University of Massachusetts Amherst

Follow this and additional works at: https://scholarworks.umass.edu/dissertations_1

Recommended Citation
Rhodes, Irvin D., "Application of labelling theory to the problems of mental illness." (1977). *Doctoral Dissertations 1896 - February 2014*. 3189.
https://scholarworks.umass.edu/dissertations_1/3189

This Open Access Dissertation is brought to you for free and open access by ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctoral Dissertations 1896 - February 2014 by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

312066016094405

APPLICATION OF LABELLING THEORY TO THE PROBLEMS OF MENTAL ILLNESS

A Dissertation Presented

By

IRVIN E. RHODES

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1977

School of Education

c Irvin E. Rhodes 1977

All Rights Reserved

APPLICATION OF LABELLING THEORY TO THE PROBLEMS OF MENTAL ILLNESS

A Dissertation Presented

By

IRVIN E. RHODES

Approved as to style and content by:

Jack W. Wideman, Chairperson of Committee

R. D. Jackson, Member

James Wright, Member

Mario Frantini, Dean
School of Education

DEDICATION

This dissertation is dedicated to my Mother and Father, Alonzo and Bertha Rhodes, whose support has sustained me through my entire educational process.

ACKNOWLEDGEMENTS

Throughout the process of writing this dissertation certain individuals were critical to its success. I therefore wish to acknowledge the advice, encouragement, and support given to me by my chairperson, Dr. Jack Wideman, during the entire dissertation process. I further wish to acknowledge the contributions of Penny Monsein Rhodes, whose thoughts, patience, and understanding were, and continue to be, a source of strength for me. Finally, I wish to acknowledge the silent support provided by my two daughters, Caelah and Lauren.

ABSTRACT

Application of Labelling Theory
to the Problems of Mental Illness

September 1977

Irvin E. Rhodes, B.S., Southern Illinois University
M.S., Southern Illinois University
Ed.D., University of Massachusetts

Directed by: Professor Jack W. Wideman

The major purposes of this study were to document the major theoretical presuppositions of labelling theory as applied to the problems associated with mental illness. Towards this end, the theoretical presuppositions of labelling theory as delineated by Thomas J. Scheff were reformulated and were seen as constituting the following assumptions: (1) of the people referred to a state hospital for the mentally ill, the percentage referred by friends, family, or significant others, will be larger than the percentage referred by individual professionals or professional groups; (2) of the people referred, the percentage admitted and labelled mentally ill will be larger than the percentage refused admission; (3) of the people referred, the percentage admitted and labelled from the lower income level will be larger than the percentage from higher income level; (4) of the people discharged, the percentage readmitted will be larger than the percentage not readmitted; (5) of the people discharged, the percentage referred to other kinds of related mental health agencies will be

larger than the percentage not referred to these agencies; and (6) of the people referred for involuntary admissions, the percentage labelled mentally ill will be larger than the percentage not labelled.

These six assumptions were tested against admissions and discharge data of a population of eighty-three first admissions to a state hospital for the mentally ill in Western Massachusetts, during the year 1974-1975.

The results indicated: (1) that the appearance of a person at a state hospital constitutes a strong presumption of mental illness, and invariably leads to a person being labelled mentally ill; (2) that persons who are from lower income levels are more likely to be diagnosed as mentally ill than those from upper income levels; (3) that readmission of those labelled mentally ill is more likely to occur than not to occur; and (4) that those who are involuntarily admitted will invariably be diagnosed as mentally ill.

A discussion of the results and their implications for the mental health system emphasized the need for the development of alternatives to the mental hospital and the necessity for mental health professionals to reevaluate and restrict their usage of labels.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

The Mental Health System has devised numerous ways to help support those who are defined as mentally ill. Services delivered by the Mental Health System are typically delivered by professionals who have as their goal the development of viable, effective treatment programs for the problems associated with mental illness. Such services range from counseling and psychotherapy to shock treatment and other somatic therapies. These services are delivered either at a mental hospital or at numerous community mental health centers. However, in recent years, a number of issues have been raised about the effectiveness of such programs and services in alleviating problems associated with mental illness. Most of the issues raised about the effectiveness of such programs and services usually center around means of delivering services, and not about goals. Thus, the mental health system constantly struggles to develop more effective and efficient means of delivering services. In the past decade, serious issues have been raised about the fundamental principles underlying the definitional process of a person being labelled as mentally ill. The issues are focused around (1) whether such a concept as mental illness exists (Szasz, 1974) and (2) whether the process of defining a person as mentally ill adds to the problem rather

than alleviates the problem. The latter issues have to do with the effects of being labelled mentally ill on one who has been so labelled. Furthermore, the issues of labelling are seen as issues for those who do the labelling, rather than as issues for those who are labelled. Such issues raise questions about the value of labelling in mental health and its concomitant effects of stigmatizing and possible devaluing of those served by the mental health system.

The Problem

Mental health professionals and those involved in study dealing with the etiology, treatment, and outcome of mental illness have approached the field from many different perspectives. From these different perspectives have come many different conceptualizations and models which attempt to define and describe the nature, cause, course, and function of mental illness. Most of these efforts traditionally have focused on psychiatric and psychological models, which in most cases accounted for mental illness in terms of psychiatric classifications, or by individual psychological mechanisms such as anxiety, stress, breakdown of defense mechanisms, and loss of ego strength.

Most of the psychiatric and psychological models developed by theoreticians and researchers involved in the study of mental illness fall within two broad definitional models. The first views mental illness as a condition in

which the person has difficulty dealing with the day-to-day problems of living, i.e. job, family, school, etc. This model is usually referred to as the personal adjustment model. The second model defines mental illness as a deviation from expected patterns of behavior or from some modal assumptions of what constitutes normative behavior. Within each of these models there is a wide variance as to what is and what is not mental illness. This lack of agreement, coupled with the lack of a sound consistent theory of mental illness, can be attributed to a reliance on individualistic models of mental illness whose conceptual structure does not include the role of certain social processes, and leaves unquestioned some of the fundamental assumptions underlying such models.

Findings in the areas of sociology, anthropology, and other allied fields have cast extreme doubt on the validity of the traditional psychological and psychiatric models. The rapid rise of research in these two fields has demonstrated with compelling documentation the necessity of investigating the social environment and the concomitant social processes involved in the phenomenon of mental illness.

One of the foremost theoretical models, among the emergent models, is the societal reaction model. The societal reaction model uses knowledge from the field of symbolic interaction and treats mental illness as a category of deviance, and as such, sees mental illness as a phenomenon of

societal processes which have direct consequences for the individual. This model as noted by Erikson (1962, p. 11):

> . . .believes that deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audience which directly or indirectly witness them. The critical variable then in the study of deviance is the social audience, rather than the individual person, since it is the audience which eventually decides whether or not any given action or actions will become a visible case of deviance.

A number of theories have been put forth to define and delineate the societal forces at play which lead to an individual being designated as mentally ill (deviant). One of the most popular of these theories is the labelling theory of mental illness. Labelling theory assumes that mental illness is defined and labelled as mental illness within the context of interpersonal relations of a given group or subgroup of a society. Thus, labelling theory assumes that it is society's reaction to certain forms and patterns of acts (rule breaking) which result in any behavior being labelled mental illness. This perspective treats mental illness as a form of deviance and as Becker states (1963, p. 9):

> . . .deviance is not a quality of the act a person commits, but rather a consequence of the application by others of rules and sanctions to an offender. The deviant is one to which that label has successfully been applied; deviant behavior is behavior that people so label.

This perspective has received a lot of attention and

has contributed much to the study of mental illness. However, until recently, this perspective has not systematically documented its major theoretical presuppositions.

Purpose of Study

This study intends to document selected theoretical presuppositions of the labelling perspective and its application to the problems associated with mental illness. The major focus of this study will be on describing and delineating the processes and steps involved in a person being labelled mentally ill and the consequences such labelling has on the "career" of the person as a client in the mental health system.

The major theoretical tenets of labelling theory as delineated by Scheff (1975, p. 11) are:

1. Residual rule breaking arises from fundamentally diverse sources (that is organic, psychological, situations of stress, volitional acts of innovation or defiance).

2. Relative to the rate of treated mental illness, the rate of unrecorded residual rule breaking is extremely high.

3. Most residual rule breaking is "denied" and is of transitory significance.

4. Stereotyped imagery of mental disorder is learned in early childhood.

5. The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.

6. Labelled deviants may be rewarded for playing the stereotyped deviant role.

7. Labelled deviants are punished when they attempt to return to conventional roles.

8. In the crisis occurring when a residual rule breaker is publicly labelled, the deviant is highly suggestible and may accept the label.

9. Among residual rule breakers, labelling is the single most important cause of careers of residual deviance.

For the purposes of this study, Scheff's presuppositions will be reformulated and are seen as constituting the following assumptions:

Assumption 1. Of the people referred to a state hospital for the mentally ill, the percentage referred by friends, family, or significant others, will be larger than the percentage referred by individual professionals or professional groups.

This assumption is seen to relate to Scheff's presuppositions four and five. Additionally, this assumption can be seen as directly related to societal reaction to residual rule breaking which constitutes the first step in the labelling process. Furthermore, documentation of this assumption can be seen as a strong presupposition of mental illness, which has direct consequences for a person being admitted to a state hospital and subsequently being labelled mentally ill.

Assumption 2. Of the people referred, the percentage admitted and labelled mentally ill will be larger than the percentage refused admission.

This assumption is related to the first since the persons who are referred are referred by non-professionals whose knowledge of mental illness is questionable but, whose reaction to a person breaking residual rules constitute such a strong presupposition of mental illness that they are admitted by professionals and subsequently labelled mentally ill.

Assumption 3. Of the people referred, the percentage admitted and labelled from the lower income level will be larger than the percentage from higher income level. An implicit assumption of labelling theory is that those who have fewer resources and those who are on the margins of society are further away socially from the label makers, and therefore, less able to resist being labelled.

Assumption 4. Of the people discharged, the percentage readmitted will be larger than the percentage not readmitted. This assumption is seen to be related to Scheff's presuppositions six, seven, eight, and nine. Additionally, this assumption can be seen as documenting the labelling perspectives' argument that the status as a deviant (especially after undergoing a status degradation ceremony, namely, being publicly labelled and admitted to a state hospital) is a master one which over-rides all others and relegates one to a deviant role and subculture.

Assumption 5. Of the people discharged, the percentage referred to other kinds of related mental health agencies

will be larger than the percentage not referred to these agencies. This assumption suggests that once a person is labelled deviant by society, they are subsequently forced into a deviant role and that this role is reinforced by society who sets up agencies to deal with those who have been labelled deviant, and whose clientele are seen as deviant. Additionally, this assumption suggests that this is a process which is highly illustrative of the career of a client (deviant) in the mental health system.

Assumption 6. Of the people referred for involuntary admissions, the percentage labelled mentally ill will be larger than the percentage not labelled. There is such a strong presupposition of illness for those who are involuntarily admitted that they are almost routinely declared mentally ill. Additionally, this represents the strongest societal reaction possible for residual rule breaking.

It is hoped that this study will demonstrate, through the application of the labelling perspective to the problem of mental illness, a clear linkage between the assumptions of labelling theory and the career of the client in the mental health system. This study will seek to demonstrate that a person who is labelled mentally ill is so labelled because of residual rule breaking, and that the rule breaker is labelled mentally ill within a process which is initiated by the reactions of others to certain acts. Furthermore,

that once these acts are called to public attention, various agencies proceed to officially label the acts as deviant and the person so labelled begins his/her career as a client in the mental health system. Thus, this study will show that, with the help of society (who dispenses rewards and punishments for failure to maintain the label), the person so labelled begins the process of incorporating the label into his/her self-concept.

Method of Study

In mental illness, the official act of labelling begins when a person presents himself/herself for admission to a mental hospital. Therefore, the method of study will take the form of examining official documents of a state hospital within the Department of Mental Health's Region, Area III (Appendix A). The documents studied will be intake, admissions, and discharge data for the year beginning March 1, 1974 to February 28, 1975. It is expected that these documents and the information contained in them will yield sufficient information to substantiate or not substantiate the assumptions of this study.

Definitions and Limitations of the Study

For the purposes of this study, the following definitions are used:

Deviance: the term deviance when used will mean the breaking of certain implicit and explicit socially agreed upon

rules. Such rules may be known or unknown to the rule breaker.

Client Career: refers to the sequence of client movements from one position to another in the mental health system made by an individual who has been admitted into the system.

Labelling Theory: labelling theory as used in this study refers to a process by which certain acts, deemed unacceptable by society, are labelled deviant. As such, labelling theory is not concerned with, nor does it see as relevant, individual acts of defiance, but rather society's reaction to deviant acts (Becker, 1963; Scheff, 1975).

Rules: rules refer to certain explicit understandings of social conduct. Thus, rules are seen as norms which govern the conduct of people in their day-to-day interactions with one another. Infractions of such rules have standard names, such as theft, adultery, breaking and entering, etc. (Scheff, 1975).

Residual Rules: residual rules are implicit understandings of everyday conduct. These rules are unspoken assumptions about how one ought to behave. As Scheff stated (1975, p. 7):

> . . .society has countless unnamed understandings . . .for convenience of society, offenses against these unnamed residual understandings are usually lumped together in miscellaneous catchall category. If people reacting to an offense exhaust the conventional categories that might define it (e.g., theft, prostitution and drunkenness) yet are certain that an offense has been committed,

> they may resort to this residual category. In earlier societies, the residual category was withcraft, spirit possession or possession by the devil: today it is mental illness.

Some examples of residual rules are:

In a conversation, instead of looking at the other person's eyes or mouth, their ears are scrutinized (Scheff, 1975), staring into the distance for hours on end, continuous talking, holding conversations with one's self, and making explicit that one really does not exist and proceeding to act that way.

Mental Illness: mental illness as used in this study refers to breaking or violation of residual rules, and the subsequent successful affixing of a label to the residual rule breaker.

Lower Income Level: lower income level will refer to persons with incomes below Poverty Level ($3,500). In addition, it is seen as being synonymous with the term, lower socioeconomic class.

This study is limited to the investigation of how society reacts to certain overt acts which violate residual rules, and as such, does not concern itself with the physiochemical or psychological processes which may lead to abnormal behavior. Additionally, this study limits itself to the actual processes by which one comes to be labelled mentally ill. Furthermore, the data which are presented are neither random nor representative of any specified population, and

the generalizability of the data is limited, except insofar as they are relevant to the previously noted assumptions.

Significance of Study

The field of mental health has always relied upon specific diagnostic categories (labels) as an aid in determining, treating, and preventing mental illness. These diagnostic categories have helped in focusing specific treatment modalities on problems associated with mental illness. However, many mental health professionals have become increasingly aware of the consequences of relying heavily on such diagnostic categories. This awareness of the consequences of labelling has focused mainly upon the way such labelling invariably draws negative attention to the person so labelled, and the way labelling places a person in a position which makes it harder for him/her to continue the normal routines of everyday life. Therefore, labelling is increasingly being seen as a way in which an individual's identity is gradually supplanted by a "stereotype which emphasizes the need, problem, or liability, and thus becomes the main aspect of the individual" (California Department of Health, 1977). Thus, labelling is increasingly being seen in terms of how it affects the value and status of a person so labelled. Given the increasing sensitivity of the effects of labelling, it is important that mental health professionals understand and appreciate the various theoretical models as-

sociated with labelling and the possible resultant outcomes.

Chapter Overviews

The study will begin in Chapter II with the presentation of the conceptual and theoretical review of labelling theory and deviance. Additionally, Chapter II will present some of the major criticisms of labelling theory. Finally, Chapter II will present the findings of other previous studies related to the major assumptions under study. Chapter III will consist of the methods used in the study and a presentation of the data. Chapter IV will consist of the analysis and interpretation of the data. Chapter V will summarize the major findings of the study and its implications for the mental health system.

C H A P T E R I I

THEORETICAL BACKGROUND AND REVIEW OF LITERATURE

This chapter seeks to provide a theoretical referent and overview of conceptual and investigative literature pertaining to the labelling perspective and deviance. The second objective of this chapter is to provide a basis for further examination of the assumptions of this study.

The chapter will be presented in three sections. The first section will present a general overview of labelling theory and deviance. The second section will seek to present the major criticisms of labelling theory, and how these criticisms have been answered. Finally, the third section will deal with specific studies related to the six assumptions of this study.

Labelling Theory and Deviance

Historically the genesis of labelling theory is contained in a book published by Tannenbaum in 1938 called Crime and the Community. In this work Tannenbaum (1938, p. 19) stated:

> The process of making the criminal is a process of tagging, defining, identifying, segregating, describing, emphasizing, making conscious and self conscious: it becomes a way of stimulating, suggesting, emphasizing, and evoking the very traits that are complained of. The person becomes the thing he is described as being. Nor does it seem to matter whether the valuation is made by those who would punish or those who would reform.

The second major development in the labelling perspective is contained in Lemert's (1951) book on social pathology. In this book Lemert provided the basic outline for the labelling perspective. A third event which added to the synthesis of the labelling perspective was the publishing in 1954 of Garfinkel's Condition of Successful Degradation Ceremonies. In this particular work Garfinkel outlined the basic process by which a person was transferred from the confines of "normal" society to that of a deviant society. These works were followed by major statements on the subject by such theorists as Goffman (1961), Kituse (1962), Erikson (1966), and Scheff (1975). A host of other works appeared throughout the 1960's and early 1970's expanding and solidifying the basic premises of labelling theory.

Labelling theory rests upon two fundamental definitions of deviance, primary deviance and secondary deviance. Primary deviance is an act or set of acts which may cause a person to be labelled deviant. Secondary deviance is behavior produced by being placed in a deviant role (Lemert, 1967). Lemert (1967, p. 19) states that:

> Primary deviation is assumed to arise in a wide variety of social, cultural, psychological contexts, and at best has only marginal implication for the psychic structure of the individual; it does not lead to symbolic reorganization at the level of self-regarding attitudes and social roles. Secondary deviation is deviant behavior or social roles based upon it, which becomes a means of defense, attack or adaptation to the overt and covert

> problems created by the societal reaction to primary deviation.

Furthermore, secondary deviance in effect causes the original deviation (primary deviation) to recede, and gives way to the central importance of the "disapproving, degradational, and isolating reactions of society" (Lemert, 1967). As can be seen by Lemert's statement, labelling theorists as a rule do not attach much significance to an act of primary deviance, except insofar as others react toward the person who commits the act. Labelling theorists maintain that deviance is not wholly a quality of the act, but is in fact the reaction produced by interaction between the person who commits the act, and those who respond to it (Becker, 1963; Erikson, 1962). Scheff (1975) and Becker (1963) see this same process in operation, but describe it as reaction to rule breaking behavior. Becker (1963) states:

> . . .social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders (p. 9).

Scheff in a similar statement, but relative to residual rule breaking, stated that:

> . . .for convenience of the society in construing those instances of unnamable deviance which are called to its attention, these rule violations may be lumped together into a residual category (p. 7).

Labelling theorists make distinctions between rule breaking and deviance. They argue that some people can break rules and not be labelled deviant. This can occur for any number of reasons, but the primary reason is that rule breaking in and of itself does not constitute deviance. However, once a rule breaker is brought to public attention, s/he becomes a deviant.

An implicit assumption of labelling theory is that an individual's personal and social attributes can affect the way others respond to an act of deviance. Thus, labelling theorists are not concerned with whether a "particular societal attribute" is related to the likelihood that an individual will commit a deviant act, but with whether that societal attribute facilitates or impedes that individual's ability to avoid being labelled deviant (Gove, 1975). Labelling theorists have argued that those on the fringes of society, particularly those who have little power and few resources (Gove, 1975), are those who are least able to resist a deviant label and are therefore most likely to be channeled into a deviant role.

Labelling theorists see the process of becoming deviant as following certain prescribed steps. These steps are as follows:

1. An individual commits an act of primary deviance (rule breaking).
2. The individual who commits the act of primary deviation

is sanctioned by the group. If the group decides that the infraction is serious enough they may take steps to have the act officially and publicly recognized.

3. Once the act is officially and publicly recognized, the act is labelled deviant within the context of some public ceremony (trial, admissions proceedings, and other public hearings). As Erikson (1966, p. 20) states:

> The ceremony is a sharp rite of transition at once moving the individual out of his normal position in society and transferring him into a distinctive deviant role. The ceremonies which accomplish this change of status, ordinarily, have three related phases. They provide a formal confrontation between the deviant suspect and representatives of his community (as in the criminal trial or psychiatric case conference); they announce some judgment about the nature of his deviancy (a verdict or diagnosis for example), and they perform an act of social placement, assigning him to a special role (like that of a prisoner or patient) which redefines his position in society.

4. Once the person is so publicly labelled, the labelled person is then recognized as a deviant (secondary deviance) and others respond to him/her as deviant. Moreover, the process is seen as irreversible, because the status of a deviant is a "master status which overrides all other statuses in determining how others will react towards the person" (Becker, 1963, p. 21).
5. The deviant's self image is changed and s/he accepts the label as deviant (secondary deviance). This step

occurs as a result of the deviant being forced into a deviant sub-culture by the agencies who are organized to "rehabilitate" the deviant. Such agencies are characterized by other individuals who have gone through the same rite of transition into deviancy and who accept their label.

6. Once labelling has occurred, it is difficult if not impossible to break out of the deviant status. Lemert (1967, p. 51) observed that:

> He/she has already failed in the normal world, suggesting to him or herself and others an inability to make it even when things are relatively normal; now (s)he faces the world as a stigmatized person. If he or she is in an institution, such as a mental hospital or prison, to become a candidate for reinstatement in society (s)he must give allegiance to an often anomalous self-conception and view of the world. Denial of the organizational ideology may lead to the judgment that the deviant is unreformed or still sick. Even in the community, the deviant presumably will face an audience which anticipates the worst and which will take steps to protect itself which will make it difficult for the person to succeed.

The labelling perspective, in summary then, focuses on society's reaction to persons who commit deviant acts. It seeks to describe the process of labelling as having serious consequences for those who are so labelled (especially if a person has passed through a degradation ceremony) and how the deviant is forced to become a member of a deviant sub-

culture. It further believes that the process of becoming a deviant is, in effect, a socialization process which has profound consequences for the person's self-image, and consequently behavior guided by that self-image.

Criticisms of Labelling Theory

Criticisms of labelling theory have taken three forms. The first form views labelling theory as not being scientific in that it lacks clear denotative definitions, and does not state explicitly its intentions. The second criticism questions the relative importance of labelling theory as compared to other normative ways of conceptualizing deviance. The third criticism is related to the tendency of labelling theory to study those who do the labelling rather than those who are labelled. Moreover, this criticism is aimed at labelling theory's explicit turning away from traditional sociological assumptions about deviance.

The first criticism views labelling theory as not being very useful, in that its denotative definitions are not sufficiently unambiguous (Gibbs, 1972), and it does not make its intensions clear. Scheff (1975) has pointed out that virtually every other sociological theory lacks denotative clarity and that when applied to mental illness, he states:

> I know of no psychiatric theory of functional mental illness that is based on denotatively defined concepts. . . . Nor are such specific concepts as depression, schizophrenia, phobia, and neurosis (p. 22).

As to labelling theory's usefulness and intentions, both Scheff (1970) and Becker (1963) agree that the purpose of labelling is one of a sensitizing theory, whose function is to contradict the major assumptions of other models. They furthermore believe that labelling theory enlarges the area of study, and thereby provides a complete and explicit contrast. As Becker (1963) states:

> . . .they (labelling theorists) wanted to enlarge the area taken into consideration in the study of deviant phenomena by including in its activities of others than the allegedly deviant actor. They supposed, of course, that when they did that, and as new sources of variance were included in the calculations, all the questions that students of deviance conventionally looked at would take on a different cast (p. 179).

The second criticism of labelling theory is a criticism aimed at the adequacy of labelling theory as opposed to other theories of deviance. Gibbs (1972) and Clinard (1973) suggested that since labelling theory was based on premises which imply stability in reaction, it made such conceptions harder, if not impossible to empirically verify. In his argument, Clinard further suggested that normative conceptions of deviance were actually relative to time, place, and circumstance, and as such they could be more easily verified. Gibbs (1972) argues similarly when he states:

> . . .still another advantage of a normative over a reactive conception is that it permits research on the empirical relation between deviant acts and the character of reactions to those acts (p.

Becker (1973) challenges this view of labelling theory by pointing out that in actuality labelling theory,

> . . .created a four cell property space by combining two dichotomous variables, the commission or noncommission of a given act and the definition of that act as deviant or not. The theory is not a theory about one of the resultant four cells, but a theory about all four of them and their interrelations (p.

As can be noted in Becker's statement, labelling theory stresses the importance of the interrelationship of actors, time, place, and circumstance, and therefore can be seen as a holistic theory of deviance.

The final criticism assumes that labelling theorists are anti-establishment. This assumption sees the attack mounted by labelling theorists against conventionally held principles as being tantamount to subversive activity. This particular criticism takes two forms. The first sees labelling theorists as siding with the underdog, and equating the underdog with those on the margins of society (Gove, 1975). As Becker (1963) states:

> Many critics believe that these theories of deviance openly or covertly attack conventional morality, willfully refusing to accept its definitions of what is and is not deviant, and calling into question the assumptions on which conventional organizations dealing with deviance operate (p. 179).

The second sees labelling theory as differing radically from the more traditional sociological explanation of deviance.

Both of these forms of criticisms can be seen as a reaction to what Scheff called the "sentizing value" of labelling theory; that is, labelling theory has a "rich evocativeness," one which shatters conventional lines of thinking. Moreover, labelling theory seems to offer a relatively detached scientific way of studying certain types of social problems. But, as Lemert (1972) noted, ". . .its mood and tone and choice of research subjects disclose a strong fixed critical stance toward the ideology, values and methods of state dominated agencies." These critics see treating official and conventional viewpoints as things to be studied, instead of accepting them as fact or self-evident truth, as a "mischevious assault on the social order" (Bordura, 1967). Becker (1963) counter this argument, when he states:

> The earlier definition of the field of deviance as the study of people alleged to have violated rules respected that order by exempting the creators and enforcers of those rules from study. To be exempted from study means that one's claims, theories, and statements of fact are not subjected to critical scrutiny (p. 196).

In summary, then, labelling theory has been criticized for (1) not being scientific, (2) its relative importance in face of other normative ways of viewing deviance, and (3) its tendency to support those who are labelled rather than those who do the labelling. Despite these criticisms, both critics and supporters of labelling theory agree that the theory's most important contribution is its focus on the

way labelling places the actor in circumstances which make it harder for him/her to continue the normal routines of everyday life.

Specific Studies Related to Labelling Theory and Mental Illness

In this section the review of literature will be organized according to, and presented with, the relevant assumptions of this study.

Assumptions 1 and 2. Of the people referred to a state hospital for the mentally ill, the percentage referred by friends, family, or significant others, will be larger than the percentage referred by individual professionals or professional groups. Of the people referred, the percentage admitted and labelled mentally ill will be larger than the percentage refused admission.

Labelling theorists assume that societal reactions to residual rule breaking is an antecedent to labelling. Therefore, they attempt to document and illuminate the process by which people are brought to, or appear, at a hospital for the mentally ill. In documenting this process of "client" selection, studies have found that varying definitions of mental illness are made at various places within the process, i.e., the person him/herself, families, employers, or friends. The major studies in this area of label-

ling theory concentrate upon the definitions which are made and the effects of the definitional process on the eventual decision as to who is labelled mentally ill (Mechanic, 1969).

As assumptions 1 and 2 suggest, the basic decision as to whether a person is mentally ill (violation of residual rules) is made by members of the potential clients group, and not by professionals. It further suggested that once a group decides to take action against an offending member, and move to have the person committed to a mental hospital, the mere appearance of the person at a hospital constitutes such a strong presumption of mental illness that they are almost invariably admitted. Various studies have documented the validity of this assumption. Mechanic (1962) in his observations and interviews at two California state hospitals, found that community persons who were brought to the hospitals arrived with various members of their families or group. His studies found that ninty percent of the persons he observed being escorted to the hospital in this manner were subsequently admitted.

In a study of the processes involved in one member of a family being referred by other family members to a mental hospital, Sampson (1961) found that (1) prior to a family member being referred to a state hospital, the disturbed person was contained within community settings, and (2) that it was the collapse of accomodation patterns between the

future client and his interpersonal community which rendered the situation unmanageable and which (3) ushered in the public phase of the pre-hospital crisis. In a similar study, Wood (1968) examined the admissions circumstances of 48 patients on an open psychiatric ward of a Veterans Administration Hospital. The major focus of his study was on the role of relatives prior to admission. This study found that in 33 of 48 cases, admissions followed actions and reactions to patient behavior by relatives. In addition, this study found a clear relationship between family demands and the patient's subsequent hospitalization, suggesting that hospitalization can be an expression by relatives that they were dissatisfied with the patient's behavior.

In a study focused on help-seeking and its relationship to a person being labelled mentally ill, Phillips (1963) found that the further a person moved along the continuum from initial help-seeking activity (friend, clergy, therapist, psychiatrist, etc.) to mental hospital, the more his problem was seen by others as a serious one. This study suggested that the mere act of seeking help may lead members of a group to label the person as mentally ill, and eventually lead to the actual hospitalization of the person.

The above studies focus on the role of significant others in contributing to a person eventually appearing at a mental hospital. Once the person appears at a mental hospital there is a strong possibility that s/he will be

admitted. The strong possibility that a person will be admitted to a hospital is based upon numerous studies; however, the strongest studies related to this aspect of labelling theory were conducted by Kutner (1962) and Rosenhan (1973). Kutner reported that admission procedures in Chicago's Cook county hospital were so hurried that it was impossible for anyone to determine a person's state of mental health in such a short period of time. His data showed that 77 percent of all cases brought up for admissions were admitted. This led Kutner to state:

> . . .it appeared that the alleged mentally ill is presumed to be insane and bears the burden of proving his sanity in the few minutes alotted to him (p. 378).

A similar study by Rosenhan (1973) found that the presumption of mental illness is almost routinely adhered to by professionals in mental hospitals. His findings indicated that all of the pseudo-patients (who had previous to and as a part of this study been adjudged sane by a panel of psychiatrists and who acted in "normal" ways) who presented themselves for admission to a state hospital were admitted.

A study which is related to Rosenhan's and Kutner's, but different, in that it relates to the suggestibility of psychiatric diagnosis, was conducted by Temerlin (1968). Temerlin studied four different groups of clinical psychologists, psychiatrists, and graduate students in clinical

psychology. In his study, Temerlin used a recorded conversation of an actor (specifically trained for the purpose of this study) who was undergoing an initial interview. Just before listening to the interview, the group heard a professional person of high prestige say that "the individual to be diagnosed was a very interesting man because he looked neurotic but actually was quite psychotic." The results of his study were that 60 percent of the group diagnosed psychosis when the suggestion was made, but none diagnosed psychosis in the absence of the suggestion.

Assumption 3. Of the people referred, the percentage admitted and labelled from the lower income level will be larger than the percentage from higher income level. A number of studies have indicated a direct correlation between social class and mental illness. The studies generally show that the lower the socioeconomic class the higher the incidence of both treated and untreated mental illness. These studies usually focused on three areas of the problem: prevalence, diagnosis, and treatment.

Prevalence. Prevalence of mental illness among the lower income classes has been an issue among mental health professionals for the last two decades. The issue is complicated by different definitions of prevalence: treated versus untreated cases, ecological studies versus psychiatric census studies, opposing statistical methodology and a host of other issues. It is further complicated by those

who claim that the data are inaccurate and tend to reflect a "racist point of view" (Thomas & Sillen, 1972).

The literature cited will use the term prevalence to mean either 1) the number of active cases of mental illness present in a particular population during a specified interval of time, 2) the number of new cases of mental illness occurring within a specified interval of time, or 3) the number of treated and untreated cases of mental illness.

Perhaps the earliest report of the relationship between income level and mental illness was reported by Jarvis in 1856. Jarvis reported that there were sixty-four (64) times as many cases of insanity in the lowest classes of Massachusetts than in the higher classes (Sandifer, 1962). Faris and Dunham (1939) in their historic ecological study of mental illness in Chicago found the prevalence of mental illness to be highest in lower income areas. A similar study by Klee (1964) found the prevalence of mental illness to be highest among the non-white and white lower classes of Baltimore.

Hollingshead and Redlich (1958) in their classic study of mental illness in New Haven found significant differences in the prevalence of mental illness among the lower classes. They found that the lower the class, the higher the prevalence of mental illness. In the second part of this study, Myers and Roberts (1959) reported in their book, Family and Class Dynamics in Mental Illness, that there was

an "inverse relationship between prevalence of neurosis and psychosis by social class, the lower the class, the lower the rates of nearly all types of neurosis, but the higher the rates of various psychosis" (p. 75).

The Midtown Manhattan study looked at the rates of untreated mental illness in a sub-sample of the population of New York City. This particular study found rates of mental illness to be higher in the lower classes than in the upper classes (Gruenberg, 1963). In a similar study by Pasamanick of mental illness in Baltimore, it was found that mental illness existed at a higher rate among the lower classes than among the upper classes. However, there were some significant findings that indicated that the relationship between social class and mental illness were a result of these variables being related in a highly complex manner (Passamanick, 1959).

In Dohrenwend's review of forty-three (43) community studies of untreated as well as treated cases of psychiatric disorders, he found that twenty-four (24) of these reported data on the relationship of mental illness and social class. Of these twenty-four studies, nineteen reported a higher prevalence of mental illness in the lower classes than in the upper classes (in Kolb et al., 1969).

Finally, the National Institute of Mental Health reported that fifty studies either undertaken or supported by NIMH consistently reported the higher occurence of schizo-

phrenia at the lowest social class levels (NIMH, 1975).

Diagnosis. The higher prevalence of mental illness among the lower socioeconomic classes can be seen as a function of how diagnoses are made in general and how diagnoses are related to social class in particular.

In general, diagnosis of mental illness can be made by a number of instruments which are applied to communities, groups or individuals. In communities, such instruments are constructed to determine psychiatric disability by using various epidemiological measures. A close examination of these measures will reveal that they are designed and constructed on the basis of various definitions and conceptualizations of mental illness whose basis is a failure to include normalic dimensions of the lower socioeconomic class, and therefore, can be seen to yield a higher prevalence of mental illness among these classes. Studies that attest to the viability of this observation can be seen in the work of Kingsley Davis and George Gruislin. Davis (1938) analyzed the basic assumptions of the mental health profession and found a clear value bias in the middle class "ideology of assumed scientific descriptions of mental health characteristics." Gruislin (1960) confirmed the middle class nature of mental health in his analysis of information contained in literature distributed by the mental health profession.

The clearest example of a middle class bias can be seen

when one examines literature relating to individual diagnosis and social class. Mehlman (1952), in his study of diagnosis and social class, found a clear relationship between severity of diagnosis and social class, the lower the class the more severe the diagnosis.

A study that confirmed Mehlman's findings and extended upon them was a study conducted by William Haas. Haas (1960) looked at the role of socioeconomic class and examiner bias. In this particular study, Haas sought to confirm (or not confirm) 1) that social service reports identifying the environmental origins and socioeconomic status of the patient would influence estimates of adjustments obtained from Rorschach protocols, and 2) that Rorschach protocols interpreted as originating from a lower class level of society would tend to be diagnosed as less adjusted than the same records designated as being from a higher class. The experiment consisted of 75 clinical psychologists being given Rorschachs of clients who had similar psycho-social histories, except for that of socioeconomic class. The pairs of Rorschachs given the psychologists were roughly similar in terms of content. Each psychologist was given the completed Rorschach tests along with an attached social history sheet. The results showed a clear bias in terms of diagnosis and social class. There was a tendency to diagnose character disorder or psychosis for lower-class patients, as opposed to normal or neurotic for middle-class

clients. Thus, this study showed a clear class bias in relation to prediagnostic impressions, diagnostic scores and prognostic scores.

In a review of the literature on social class and projective test, Riessman and Miller (1964) found most personality tests indicated that the lower class is more maladjusted than other classes. They suggested that this may be more reflective of the middle class norms of the test than to any psychological variables of lower class clients. They cautioned clinicians who use projective tests with lower class clients to take into consideration the possible effects of the testing situation, language referents, educational differences and class rapport in interpreting the results of such tests.

Treatment. In light of the nature of diagnosis and social class, it is not surprising that the treatment afforded lower class clients would be reflective of this process. This can be seen in terms of such treatment factors as: intake practices, kinds and types of treatment and hospitalization. Writers such as Pollack and Fink, Overall and Aronson, and Cole who looked at the differential nature of treatment and social factors in selection for therapy found that the intake interviewer tended to see lower class clients as less treatable than upper class clients and viewed them in less positive ways. They also had a tendency to relate low social status to such things as: lower

intelligence, less education, to seeing presenting problems as physical rather than emotional, desire for symptomatic relief only, rather than overall help, lack of understanding of the therapeutic process, and lack of desire for therapy. These writers concluded that since the intake interviewer tended to see lower class clients in these ways, they tended to refer them less often for therapy. In a similar study, Shostack (1969) reported that lower class clients were perceived by therapists as not benefiting, being interested in, or amenable to individual therapy and were therefore rejected from the outset.

Brill and Storrow (1968) studied the relationship between social class and acceptance for psychiatric treatment. Their findings supported earlier studies that showed lower class clients being accepted into therapy or other kinds of psychiatric treatment less often than those from upper classes. A similar study by Bahn (1966) found that lower class clients were less likely than other classes to be admitted to a hospital or to receive outpatient treatment in the early stages of mental illness (Bahn et al., 1966).

A series of studies by the National Institute of Mental Health (1974) concluded that upper class clients received treatment that differed according to their symptoms, while lower class clients received drugs, regardless of the presenting symptom.

Studies by Schaffer and Myers (1954) and Rosenthal and

Frank (1970) found that when money was not a factor in access to treatment in an outpatient clinic, upper class clients were accepted for treatment more often and assigned better and more experienced therapists than those from other classes.

Perhaps the most important studies in this area were conducted by Hollingshead and Redlich (1959) and the subsequent follow-up to their study by Myers and Bean (1960). Hollingshead and Redlich found that in terms of treatment the lower class clients were: 1) dismissed from treatment much more quickly than patients from upper classes (when neurotic); 2) lower class psychotics were rarely perceived as ready to leave treatment, whereas the higher class psychotics were; 3) lower class patients were more likely to routinely receive custodial care, as opposed to corrective forms of therapy; 4) mean cost per day in private hospitals was higher for low income patients than for high income patients; 5) the higher status person received more therapy than the lower status person; 6) higher status groups were more likely to be referred by themselves or by friends and families, while lower status persons were more likely to be referred by the police or the courts; 7) higher status persons who were disturbed were gently urged in insightful ways to seek help, whereas the lower class client was urged to seek help by "direct authoritarian, compulsory, and at times coercively brutal methods"; 8) psychotherapeutic methods, in

particular insight therapy, are applied to higher status neurotics and psychotics, as opposed to organic therapy (electro-convulsive treatment) for lower status neurotics and psychotics; and 9) lower class clients stayed hospitalized longer and were discharged later than upper class clients.

In their follow-up to Hollingshead and Redlich's study, Myers and Bean found that ten years after the original study was conducted that: 1) 57% of the lowest class were still hospitalized, as opposed to 39% of the upper class patients; 2) from those discharged and living in the community, 31% were from the upper classes, while only 10% were from the lower classes; 3) of those receiving outpatient care, only 10% were from the lower classes versus 33% from the higher classes; 4) 100% readmitted upper class patients were discharged, as opposed to 57% of readmitted lower class patients; 5) the higher the class, the greater the percentage of patients discharged, for first as well as readmission and discharge--the lower the class the higher the percentage of discharged patients who were again hospitalized; 6) lower class persons were more likely to be readmitted by courts or police; 7) the higher the class the more likely the patient is to receive a type of therapy associated with favorable treatment outcome; 8) the higher the class the greater the proportion of patients receiving outpatient care, those who receive outpatient care were less

likely to be readmitted, among persons receiving no outpatient care, the chances of remaining out of the hospital were greater for those in the upper classes; and 9) the higher the class the greater the amount and intensity of therapy.

Assumptions 4 and 5. Of the people discharged, the percentage readmitted will be larger than the percentage not readmitted. Of the people discharged, the percentage referred to other kinds of related mental health agencies will be larger than the percentage not referred to these agencies.

As these assumptions suggest, admission into a mental hospital constitutes a public degradation ceremony which has profound effects on the person's self-concept and on how s/he is viewed by society. They further suggest that the status change from a "normal" person to that of a labelled deviant launches the person on a career as a client in the mental health system.

In an attempt to identify feelings of stigma among relatives of formerly hospitalized patients, Freeman and Simmons (1961) studied 714 cases where the patient was referred back to his/her family. Their findings indicated that the number of families reporting feelings of stigma was significant, and that there was a significant level of concealment and withdrawal from social contacts by these families.

In a study of socially unfavorable attitudes exhibited toward persons who have been hospitalized for mental illness, Whately (1959) found that a "lingering social stigma was attached to newly discharged patients." He saw this as having consequences for the social relations of the former client in terms of social distance, distrust, or denial of employment. Freeman and Simmons (1958) found that there was a high correlation between expectation of performance and family settings. Their findings indicate that continued acceptance of the former patient by his significant others is a key factor affecting the process of post hospital experience. They saw this acceptance as crucial to whether or not the patient succeeds in remaining in the community or is rehospitalized. Their study linked continued acceptance with tolerance of deviancy, that is, the more significant others could tolerate deviant acts of the former patient, the less likely s/he would be rehospitalized. Phillips (1963) presented housewives with vignettes describing various forms of disturbed behavior (i.e., that of a normal individual, a phobic compulsive, a simple schizophrenic, and a paranoid schizophrenic). He found that, controlling for the type of disorder, disturbed behavior was positively related to rejection. Similar findings were reported by Bentz and Edgerton (1971), Spiro (1973), Schroder and Ehrlich (1968), and Bord (1971).

Several studies (Swanson & Spitzer, 1970; Kirk, 1974;

Schwartz et al., 1974) sharply differ from the above findings. These studies looked at relatives before hospitalization, during hospitalization, and after hospitalization. The rates of rejection that they found were very low.

The above studies have dealt with attitudes and feelings of stigma on the parts of significant others in relation to former patients. Several studies focus on the experiences and feelings of the former patients themselves. Cumming and Cumming (1965) found that 41 percent of the former patients they studied had feelings of stigma, and expressed feelings of shame, or a generalized expectation of discrimination. Gove and Fain (1973) obtained mixed results in their studies. Their results indicated that 72 percent of the former patients they studied saw hospitalization as having both negative and positive effects.

Assumption 6. Of the people referred for involuntary admissions, the percentage labelled mentally ill will be larger than the percentage not labelled. The number of studies in this area are remarkably sparse. However, Scheff's (1964) study is considered to be a major one in this area and can be seen as illustrative of the process of involuntary commitment. Scheff's study consisted of ratings of a sample of patients newly admitted to the public mental hospitals in a Midwestern state, official court records, interviews with court officials, psychiatrists, and observations of psychiatric examinations in four courts. His find-

ings indicated an overwhelming presumption of illness on the part of the mental hospital. This presumption was so strong that not a single person was recommended for release from a mental hospital, even when the person did not meet the criteria for involuntary admission set by the state and the hospital. Scheff's findings are similar to those of Kutner (1962), whose studies were mentioned previously in this section. In addition to these two studies, hearings on the constitutional rights of the mentally ill held by the U.S. Congress (1961) found that 90 percent of all hospitalized patients in the United States are confined involuntarily.

In summary, this section of the study focused upon the six assumptions of this study and the related literature. It sought to establish the phases of the client career and the concommitant societal reaction which reinforces the continuation of that career. These phases have been seen as being composed of five distinct events. The first event consists of an individual engaging in some public action or set of actions. The second event represents the process whereby the behavior is evaluated and defined as deviant. The third event is a decision which comes about if the individual fails to adjust his/her behavior to conform to the expectations of those persons who have defined the behavior as unacceptable. The fourth event is the attachment of a professional definition to the patient's hospital entry status. The fifth and final event (more accurately, contin-

uous event) is the process related to the career of the deviant as a client in the mental health system, i.e. readmission, referral to other agencies, and continued aftercare. Additionally, studies related to lower income level and involuntary admissions were reviewed.

C H A P T E R I I I

METHOD OF STUDY

The previous chapter provided an examination of the theoretical and conceptual considerations regarding labelling theory and its application to mental health.

This chapter will describe the methods used in collecting data related to the six assumptions of this study. This chapter is presented in two sections. The first section will describe in some detail the nature of the population studied. The second section will delineate the methods used in collecting and analyzing the data.

Population Studied

There were two major concerns in collecting data for this study. The first matter of concern was selecting an appropriate population for study. Given the author's knowledge about the regional and area organization of the Department of Mental Health, it was decided to choose a mental health area within Region I which fit the general thrust of the purposes of this study. As pointed out earlier, the area chosen was the H-C area. There were several reasons for this choice, but the major reason was the relative mix of suburban, urban, and rural populations.

The second matter of concern related to collecting specific data from this mental health area relative to the six

assumptions of this study. Before beginning to collect data, the author generated certain criteria which guided the selection of a data year. These criteria were: (1) data must represent a continuous period of time of one calendar year, (2) the data must be based on data generated from official documents of the Department of Mental Health, (3) the data must be as complete as possible in the categories studied, and (4) the data must contain data relevant to testing the six assumptions of this study.

After consulting various documents and officials of the Department of Mental Health, it was decided that data from the H-C mental health area for the period of March 1, 1974, to February 28, 1975, met all four criteria.

The data obtained from the H-C mental health area were admissions and discharge information. Additionally, admissions and discharge surveys completed by this mental health area were obtained.

The population studied was from the H-C mental health area. This area is an area within the Department of Mental Health's Region I (see Appendix A), and is an area formed to deal with the mental health needs of a defined population within certain geographic limits. The H-C area is located in central western Massachusetts and is composed of the towns of Holyoke, Chicopee, Belchertown, Granby, Ludlow, Southampton, and South Hadley.

This area has a population of 165,843 and is character-

ized by a large urban area with surrounding suburban to semi-rural communities (see Table 1). Seventy percent of the area's population is concentrated in the cities of Holyoke and Chicopee (see Table 1). Both Holyoke and Chicopee are characterized by typical urban problems, such as large numbers of substandard housing and high unemployment. Approximately seven percent of the population of Holyoke and Chicopee are unemployed. In these two communities, ten percent and five percent respectively are below the poverty level and receiving welfare assistance (see Table 2). In addition, there is a large Spanish-speaking population concentrated in Holyoke and Chicopee (see Table 2).

Because of the nature of the H-C area, it has been designated a poverty area by various federal agencies, including the National Institute of Mental Health. This designation has enabled the area to receive federal assistance in the form of a Regional Opportunity Program, model cities, and a Community Action Program.

The H-C catchment area has direct ties to the state hospital for the mentally ill located in Northampton. Each area within the Department of Mental Health's Region I is responsible for a particular unit (designated by the area's name) at the state hospital. Therefore, there is a H-C unit located at the State Hospital which houses those persons admitted to the state hospital from the H-C area.

During the year studied (1974-1975), the State Hospital

TABLE 1

Population Profile of H-C Mental Health Area

Towns in Area	Total	0-17 yrs.	18-65 yrs.	65+ yrs.	Black	Spanish speaking/ Puerto Rican
Belchertown	5,936	2,071	3,460	459	63	--
Chicopee	66,676	24,058	29,801	5,743	1,246	2,084
Granby	5,473	2,393	2,666	414	19	--
Holyoke	50,112	16,887	25,583	7,642	1,127	5,036
Ludlow	17,580	6,380	9,911	1,289	6	254
Southampton	3,069	833	2,007	229	0	--
South Hadley	17,033	6,792	8,789	1,452	59	--
Totals	165,843	59,360	82,217	17,228	2,522	7,374

Total Area--198.07 square miles

NOTE: From United States Department of Commerce Census Facts.

TABLE 2

Income Profile of H-C Mental Health Area

	Family income median	Family income mode	% families below poverty level	% of those below poverty level receiving assistance
Belchertown	$9,029	$10,362	8.8	6
Chicopee	9,738	10,528	5.4	23
Granby	10,448	11,357	6.6	8
Holyoke	9,218	10,277	10.6	33
Ludlow	10,900	12,465	4.5	10
Southampton	10,693	11,256	4.9	--
South Hadley	11,300	12,500	8.2	(?)

Area unemployment figures, January 1974 = 7.7%

NOTE: From Massachusetts Division of Employment Security

had an inpatient population of 598, with total admissions for the year being 1,148 (see Appendix B). The H-C Unit (Unit III) for the same year had a total inpatient population of 272 with total admissions for the year being 212.

For the purposes of this study, those who were admitted for the first time during the year 1974-1975 were studied. As can be noted in Table 4, there was a total of 83 persons who were admitted for the first time. Although there were 129 who had previous admissions, these were not studied because of that fact. It was felt by the author that those who were first admitted afforded a better opportunity to apply the assumptions of this study. This particular population comprises the total of all those admitted for the first time during a period from March 1, 1974, to February 28, 1975.

As can be seen in Table 5, those who were admitted for the first time came from all the seven towns of the H-C area. As Table 5 shows, those who were admitted for the first time are generally characterized as being predominantly young, male, white, and poor.

In summary, this section presented some descriptive information on the general and specific characteristics of the population studied, the mental health area from which they came. Additionally, this section presented some descriptive data on the H-C mental health area and the State Hospital.

TABLE 3

Some Descriptive Data on H-C Unit

		Male	Female	Total
1.	Number on the books June 30, 1975	71	71	142
	On visit	14	29	43
	On absence	2	--	2
	On escape or AWA	--	--	--
	In family care	--	--	--
	In residence	55	42	97
2.	Number of admissions during year	137	85	212
	Discharges during year	149	128	257
	Transfers to other hospitals	2	--	2
	Deaths during year	1	3	4

TABLE 4

Some Descriptive Data on Those Admitted:

March 1974-February 1975

Attributes	N	%
Age		
10-19	27	13
20-29	67	32
30-39	26	12
40-49	39	18
50-59	19	9
60-over	34	16
Sex		
Male	124	58
Female	88	42
Race		
Black	4	2
Caucasian	200	94
Puerto Rican	8	4
Unknown	--	--
Income Level		
Below Poverty Level	119	56
Above Poverty Level	93	44
Previous Admission		
Yes	129	61
No	83	39
Total Number Admitted	212	

TABLE 5

Descriptive Data on First Admissions

Attributes	Number
Age	
16-25	40
26-50	29
50-over	14
Race	
Black	4
Caucasian	76
Puerto Rican	3
Sex	
Male	57
Female	26
Income Level	
Below Poverty	63
Above Poverty	20
Residence	
Holyoke	41
Chicopee	18
South Hadley	8
Ludlow	6
Granby	5
Southampton	2
Belchertown	3

Method of Collecting Data

The design of this study entailed collecting six types of data related to the six assumptions detailed in Chapter I. The first type of data collected were data related to the sources of referral of those admitted to the State Hospital. These data are seen as being related to the first assumption, which assumed that a larger percentage of those referred to the State Hospital would be referred by friends, families, and other peer group members who were not professionals. The second type of data collected were information relative to rates of admissions and diagnosis. These data are related to assumption two which assumes that given the societal reaction phenomenon, then a large percentage of those who appear at the State Hospital will be admitted and labelled mentally ill. The third type of data collected were socioeconomic data. These data are related to assumption three, which assumes that a large percentage of those admitted will be from the lower classes of society. The fourth type of data collected were discharge and referral information. These data were seen to be related to assumptions four and five which assumed the career notion of an admitted person. Finally, the fifth type of data collected were involuntary admissions data. These data are directly related to assumption six which assumes that a larger percentage of those involuntarily admitted will be diagnosed as mentally ill.

The admissions data obtained were in the form of information contained on the official intake form used by the State Hospital for admissions purposes. Information contained on this form was in the area of income level, education level, problem appraisal, source of referral, previous psychiatric service, and diagnosis (see Appendix C).

The discharge data were obtained from the official discharge forms used by the State Hospital. This form contained information such as condition for release, reason for release, date of release, and various referral information (see Appendix D).

Method of Analysis

The method used in analyzing the data from this study consisted of compiling the data relevant to the six assumptions of this study and analyzing it in terms of relative proportions. Therefore, the data were analyzed according to percentages of proportions as a basis of analyzing sources of referral, admissions, diagnoses, lower class admissions, referral and discharge, and involuntary admissions. These percentages were then compared against those proportions of the same population to determine if there were a major percentage (50% or more) difference. Major proportion differences were seen as being in support of, or not in support of, the assumptions of this study.

Summary

This chapter has sought to describe the procedures used in investigating the six assumptions of this study. In order to accomplish this objective, the nature and size of the population was described as being from the H-C mental health area and consisting of 83 persons who were admitted for the first time to the State Hospital during 1974-1975. Additionally, the methods used in analyzing and reporting the data were outlined.

C H A P T E R I V

ANALYSIS AND INTERPRETATION OF DATA

This chapter presents analysis of data used to test the assumptions of this study and some tentative conclusions. The chapter is divided into two sections. The first section presents all relevant data and analysis related to evidence which supports or does not support the assumptions. The second section includes summaries of all relevant data and tentative conclusions.

Assumptions of the Study

The first assumption maintains that a larger percentage of people referred to a state hospital would be referred by friends, family, and other peer groups rather than by individual professionals or other professional groups. This assumption is seen as being related to societal reaction to residual rule breaking within a given group, and is seen as the first step in the labelling process. Furthermore, if a larger percentage of individuals who are referred to a state hospital are referred by friends, family, etc., then there exists a strong possibility that residual rule breaking was the causative variable which led the person to be referred. Moreover, this assumption is based on the fact that a person is not defined as mentally ill until such time as they are officially recognized as such by professionals.

In addition, the person must have been behaving in ways which were disturbing or unacceptable to other group members (breaking residual rules) in order for group members to initiate referral.

In order to substantiate or not substantiate this assumption data related to the sources of referral of those admitted to a state hospital for the first time were collected (Table 6). Of those referred, the largest percentages were in the following categories: (1) friends and family, 26.50%; (2) self, 24.10%; (3) nursing home, 14.45%; and (4) court or correction agency, 14.45% (see Table 6). As can be seen by these data, it cannot be said that this population was referred by friends or families in larger percentages than other sources of referral.

The second assumption, as stated in Chapter I, assumes that a larger percentage of those referred to a state hospital would be admitted and subsequently labelled mentally ill rather than refused admission. This assumption is strongly related to the societal reaction phenomenon in that the reaction to a person who violates residual rules most often leads the residual rule breaker to a mental hospital. Once s/he appears at a mental hospital the presumption of mental illness is so strong that they are invariably admitted and labelled mentally ill.

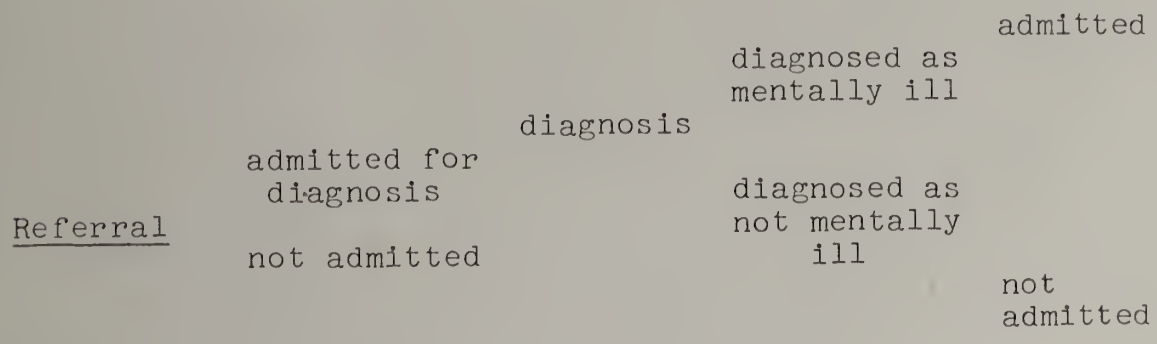
In order to understand and collect data relevant to this assumption, the admissions process of the state hos-

TABLE 6

Referral Sources of Those Admitted

Referral Sources	N	%
Self	20	24.10
Family, Friends	22	26.50
School	4	4.82
Private Psychiatrist	2	2.41
Private Physician	2	2.41
Nursing Home	12	14.45
Vocational Rehabilitation Center	2	2.41
Court or Correction Agency	12	14.45
Public Health or Welfare Agency	6	7.23
Unknown	1	1.20
Totals	80	100.00

pital had to be investigated. The process of admission to the State Hospital involved four steps: referral, admissions for diagnosis, diagnosis, and admission as a patient. When a person is referred to the State Hospital, s/he is admitted for diagnosis or not admitted for diagnosis. If a person is admitted for diagnosis s/he undergoes a psychiatric examination by a team which consists of a doctor, a nurse, psychologist, and social worker. In order to be admitted a person must meet the following criteria: (1) be psychotic, or (2) be a danger to him/herself or others (see Appendix E, H-C Unit Admissions Procedures). If a person is examined and found to meet one or both of the criteria, s/he is admitted. The following schematic representation graphically illustrates the admissions process.



In order to substantiate or not substantiate assumption two, the admission process outlined above was examined for the 83 persons admitted for the first time to the State Hospital. The data obtained demonstrated that the 83 persons referred for admissions to the state hospital were admitted

for diagnosis. A total of 80 (96%) were subsequently diagnosed as mentally ill (see Appendix F for diagnostic categories used) and admitted. A total of 3 (3.61%) were diagnosed as not mentally ill and released (see Table 7).

On the basis of the data it can be said that the larger percentage of those referred for admissions were admitted and diagnosed as mentally ill. Therefore assumption two is seen as being substantiated.

The third assumption assumes that a larger percentage of those who were admitted and diagnosed as mentally ill would be from the lower income levels rather than from the upper income levels. For this assumption lower income level was defined as income below the poverty level. The poverty level as set by the federal government for the year studied was $3500. This particular way of defining income level is consistent with the State Hospital's policy of billing for services based upon the ability and pay, and measuring ability to pay on the basis of annual income. Of the 80 persons who were admitted and diagnosed as mentally ill, 61 (76.25%) were from the lower income levels, as opposed to 19 (23.75%) from the higher income levels (see Table 8). Moreover, the towns of Holyoke, Belchertown, and South Hadley, towns which have the highest percentages of populations below the poverty level, accounted for 50 percent of those who were admitted and diagnosed as mentally ill. On the basis of these data, it can be said that persons who were from lower income

TABLE 7

Percentages Admitted and Diagnosed as Mentally Ill

	N	%
Total Referred	83	
Total Admitted	83	100.00
Total Diagnosed as Mentally Ill	80	96.38
Total Diagnosed as Not Mentally Ill	3	3.61

TABLE 8

Income Level and Admission Rates

Total Number	Place of Residence	Above Poverty Level N	%	Below Poverty Level N	%
41	Holyoke	8	10.00	33	41.25
17	Chicopee	3	3.75	14	17.50
8	South Hadley	3	3.75	5	6.25
5	Ludlow	2	2.50	3	3.75
5	Granby	1	1.25	4	5.00
1	Southhampton	1	1.25	0	0.00
3	Belchertown	1	1.25	2	2.50
80	Totals	19	23.75	61	76.25

levels were admitted and diagnosed mentally ill in higher percentages than others from higher income levels, thereby substantiating assumption three.

Assumption four assumes that a larger percentage of those who were discharged would be readmitted than not readmitted. This assumption links the labelling of a person as mentally ill with a radical change in status. This occurred by virtue of a person being admitted to a state hospital, and undergoing a status degradation ceremony (labelling) which transferred the person from the status of a person to that of a deviant. Additionally, it assumes that once a person was so labelled, the societal reaction to the label would create circumstances in the community which would make it more difficult for the person to remain in the community than in the hospital. Therefore, it was assumed that the conditions in the community coupled with the deviant status would lead a majority of those discharged to seek readmittance.

The data showed that out of the original 80 who were admitted and diagnosed as mentally ill, 69 (86.25%) were subsequently discharged (Table 9). Of the 69 discharged, 49 were readmitted, accounting for 71 percent of those discharged (Table 10).

On the basis of these data it can be seen that the larger percentage of persons who were discharged were subsequently readmitted, thereby substantiating assumption four.

TABLE 9

Discharge Data

	N	%
Discharged	69	86.25
Remained in Residence	11	13.75
Totals	80	100.00

TABLE 10

Readmission Data

	N	%
Readmitted	49	71.01
Not Readmitted	20	28.98
Totals	69	100.00

Assumption five assumes that a larger percentage of persons admitted and labelled mentally ill would upon discharge be referred to other mental health related agencies rather than not referred to these agencies. It was assumed that the label of mental illness, and the subsequent role as a deviant, would be reinforced by a person being referred to other related agencies whose populations consisted of other deviants. Additionally, this was seen as one of the components of the labelled deviant's career as a deviant.

During the course of this study 69 (86.25%) out of the original 80 (who were diagnosed as mentally ill) were discharged. Of the 69 who were discharged, 38 (47.50%) were referred to their home, self or family; 9 (11.25%) were referred to a court or correction agency; 9 (11.25%) were referred to a nursing home; 6 (7.50%) were referred to a mental health center; 3 (3.75%) were referred to psychiatric units of a general hospital; and 2 (2.50%) were referred to a halfway house (see Table 11). As can be seen by these data the larger percentage of persons referred upon discharge were not referred to other kinds of mental health agencies. This would be true even if all the other categories of referral were taken together and construed as mental health related agencies. Therefore, on the basis of this evidence assumption five cannot be said to be substantiated.

Assumption six assumes that a larger percentage of

TABLE 11

Discharge and Referral

Place Referred to	N	%
Home, self, family	38	47.50
Mental health center	6	7.50
Halfway house	2	2.50
Nursing home	9	11.25
Psychiatric hospital	2	2.50
Court or correctional agency	9	11.25
General hospital psychiatric unit	3	3.75
Totals	80	100.00

those persons involuntarily admitted would be labelled mentally ill rather than not labelled mentally ill. The data show that a total of 59 (71.08%) were admitted voluntarily (see Appendix E for admission procedures), as opposed to 24 (28.91%) admitted involuntarily. Additionally, 57 (96.6%) of those voluntarily admitted were diagnosed as mentally ill, and 23 (95.8%) of those involuntarily admitted were diagnosed as mentally ill (Table 12). On the basis of these data it can be said that assumption six is substantiated.

Summary and Tentative Conclusions

This chapter reported and analyzed data associated with the six assumptions of this study. Additionally findings not directly related to the six assumptions were reported.

Of the six assumptions investigated, it was found that the data did not support assumptions one and five. However, the data did support assumptions two, three, four, and five.

The data indicated a strong relationship between referral for admissions and being labelled mentally ill. The data indicated that 96% of those referred for admissions were subsequently labelled mentally ill. The data also indicated that while the lower class made up only 7% of the general population they accounted for 76% of the admissions. Additionally, 71% of those discharged were readmitted and 95.8% of those involuntarily admitted were diagnosed as men-

TABLE 12

Voluntary and Involuntary Admissions and Diagnosis

	N = 83		diagnosed as mentally ill N = 80	
	N	%	N	%
Voluntary	59	71.08	57	96.6
Involuntary	24	28.91	23	95.8

tally ill.

While assumptions one and five were not substantiated by the data, they nevertheless gave valuable insights into the process of referral and discharge.

On the basis of the above, it can be generally concluded that the appearance of a person at a state hospital constitutes a strong presumption of mental illness, and almost always invariably leads to a person being labelled mentally ill. Furthermore, persons who are from lower income levels are more likely to be diagnosed as mentally ill than those from the upper income levels. Additionally readmission of those labelled mentally ill is more likely to occur than not to occur. Finally, those who are involuntarily admitted will invariably be diagnosed as mentally ill.

Because of the nature of this study the conclusions drawn cannot be generalized to larger populations. However, the conclusions do lend support to some of labelling theory's basic tenets.

C H A P T E R V

SUMMARY AND RECOMMENDATIONS

This concluding chapter will be presented in two sections. The first section will summarize the substantive material presented in the previous four chapters; as such it will consist of a review of the purposes, theoretical referents, and findings of this study. The second section will discuss the major conclusions of this study and their implications for the mental health system.

Summary

The major purposes of this study were to document the major theoretical tenets of labelling theory as applied to the problems associated with mental illness. Towards this end, the theoretical presuppositions of labelling theory as delineated by Thomas Scheff were reformulated and were seen as constituting the following assumptions: (1) of the people referred to a state hospital for the mentally ill, the percentage referred by friends, family, or significant others, will be larger than the percentage referred by individual professionals or professional groups; (2) of the people referred, the percentage admitted and labelled mentally ill will be larger than the percentage refused admission; (3) of the people referred, the percentage admitted and labelled from the lower income level will be larger than

the percentage from higher income level; (4) of the people discharged, the percentage readmitted will be larger than the percentage not readmitted; (5) of the people discharged, the percentage referred to other kinds of related mental health agencies will be larger than the percentage not referred to these agencies; and (6) of the people referred for involuntary admissions, the percentage labelled mentally ill will be larger than the percentage not labelled.

Conceptual and investigative literature related to labelling theory and deviance in general, and the six assumptions of this study in specific were reviewed in order to establish the theoretical foundation of this study.

Literature related to labelling theory and deviance maintained that deviance is not wholly a quality of the actions, but is, in fact, the reaction produced by interaction between a person who commits the act and those who respond to it. Therefore, labelling theorists defined deviance as societal reaction to violations of certain rules. Thus, a person who violated certain rules was labelled, and transferred via a status degradation ceremony from the status of a person to that of a deviant.

The application of the labelling perspective's general theoretical constructs to the six assumptions of this study was accomplished through a review of related literature. The literature review documented the phases of the client career and the concomitant societal reaction which rein-

forces the continuation of that career. Additionally, the literature documented the relationship of societal reaction to the higher rates of admissions for members of the lower income levels and involuntary admissions.

Major Conclusions and Recommendations

Conclusion one. It was concluded that the appearance of a person at a state hospital constituted such a strong presupposition of mental illness that they were invariably admitted and labelled mentally ill. Ninety-six percent of those admitted to the state hospital were subsequently labelled mentally ill.

This conclusion is seen as being strongly related to societal reaction to the violation of residual rules. The strength of this assumption is reinforced when one investigates the diagnostic categories used (see Appendix F). Diagnostic categories such as marital maladjustment, adjustment reaction to adolescence, adjustment reaction to adult life, adjustment reaction to late life, inadequate personality, explosive personality, and hysterical personality were found to be used. These diagnostic categories were construed as symptoms of mental illness and, as such, were accorded the appropriate reaction by professional staff of the state hospital. It would seem from the aforementioned that the residual rules violated in the group led the person to be referred to the state hospital; once at the

state hospital the residual rule violator was declared mentally ill and given an appropriate label.

Presumably, the labels used were for the purposes of providing specific treatment for specific problems. However, as can be seen, such labels emphasize the need, problem, or liability of the individual and as such unnecessarily devalues the individual (California Department of Health, 1977).

Recommendation. The implications of the above for the mental health system are: (1) given the high risk of stigmatization associated with being labelled mentally ill, admissions into a mental hospital should not occur for problems of living (marital maladjustment, adjustment reaction to adolescence, etc.), and that all such problems should be referred to individual mental health professionals; (2) the uses of labelling needs to be reevaluated and restricted to identifying interventions and service needs of the individual.

Conclusion two. It was concluded that persons from the lower income levels are more likely to be diagnosed as mentally ill than those from the upper income levels. This conclusion is consistent with a large number of other studies on this subject. The existence of a disproportionate number of lower income persons being labelled mentally ill raises the question of whether lower income groups are committed more often because of societal reaction to their social status or because this particular social status in itself

correlated with mental illness (Scheff, 1975). This study leaves these two questions unanswered. However, it can be said that the value structure of the mental health system reflects that of the general society and hence what is good and desirable is equated with adherence to values associated with the upper classes. It can be argued that this necessarily places the lower income groups in a deviant status and that therefore by definition they would constitute a larger percentage of those who are labelled mentally ill. Viewed in this manner the higher levels of commitment of lower income groups can be seen as both a societal reaction to their social status and as a correlation of lower income levels with mental illness.

Recommendation. The implications of the above for the mental health system is that the definition of mental illness must necessarily include the value base upon which it is based. Furthermore, all efforts must be explored to insure that cultural biases do not unwittingly lead to higher commitment rates for low income groups than for other income groups. Finally, alternative methods of diagnosis, based upon culturally relative referents, must be devised and implemented in settings other than a mental hospital.

Conclusion three. It was concluded that readmission of those labelled mentally ill is more likely to occur than not to occur.

The high rates (96%) of readmission for those labelled

mentally ill supports the assumption that once a person is labelled mentally ill it is easier for them to remain in the mental hospital than in the community. Additionally, it raises questions about the validity of the criteria for admission and discharge.

The status change which accompanies a person being labelled mentally ill places the person in a deviant status, which makes it extremely difficult for the person to remain in his former group. Thus, the labelled deviant finds it easier to live among those who have also been labelled deviant.

The admission criteria used by the state hospital requires that a person be either psychotic or a danger to themselves or others. In order to be discharged, a person must not be psychotic or a danger to themselves or others. Given the admission and discharge criteria it is reasonable to suggest that the high rates of readmissions can be attributed to (1) inadequate admission and discharge criteria, (2) premature release, (3) recurrence of the "illness," or (4) inability of persons labelled mentally ill to remain in the community. As has been suggested the higher rates of admission can be attributed to the status change which accompanies a person being labelled mentally ill. To argue otherwise would suggest that the state hospital staff were acting in inappropriate and unprofessional ways.

Recommendations. If the high rates of readmission can

be attributed to a person's inability to remain in the community, and therefore remain in his former group, it then is incumbent upon the mental health system to work in ways which enhance and increase the person's ability to remain in his group upon discharge. This suggests that the mental hospital is an inappropriate referral; it further suggests that since the person's primary group is affected by a member being labelled mentally ill, it then is necessary to work with that primary group in ways which will make it easier for the person labelled mentally ill to be integrated into the group.

Conclusion four. It was concluded that those who are involuntarily admitted will invariably be diagnosed as mentally ill.

Ninty-five percent of those involuntarily admitted were diagnosed as mentally ill. As was noted earlier, involuntary commitment to a state hospital is an extreme form of societal reaction to residual rule breaking. Such an extreme reaction is reserved for those who blatantly and willfully violate residual rules, or who break such residual rules in connection with the breaking of standard societal rules (for example, breaking and entering). Given the extreme societal reaction to such residual rule violation, it is not surprising that staff of a state hospital for the mentally ill would also routinely label such referrals as mentally ill. This can be attributed to the strong pre-

sumption of mental illness created by the suggestion effect of formal agencies (court, correction agency, etc.) on professionals who are involved in admission proceedings.

Recommendations. Involuntary commitment requires that a court of law rules that a person is psychotic or a danger to themselves or others. The evidence for such a ruling is presented by those same professionals who originally declared the person to be mentally ill. This implies that the professionals are impartial and that there is no conflict of interest. However, as was noted, the strong presupposition of mental illness created by the formal agency's referring a person for involuntary commitment exerts a strong effect on the professionals involved. Therefore, the professionals have been biased, and furthermore, any testimony presented by these professionals should be considered as not only biased but as a conflict of interest. In as much as the professionals originally diagnosed a person as mentally ill, it then is in their professional interest for the court to rule similarly. Given this, it is suggested that involuntary admissions are not within the purview of a mental hospital and therefore should be referred to other agencies for evaluation. If other agencies find the person to be "mentally ill," other agencies should be considered for the delivery of the required services. The mental hospital should be considered to be the last alternative.

In summarizing the implications and discussions of the

major conclusions of this study, it must be reemphasized that data from this study does not permit generalizations beyond the population studied. However, by using the data generated by this study, along with data from other relevant studies, the conclusions can be seen as supportive of the theoretical presuppositions of labelling theory.

REFERENCES

Ausubel, R. Personality disorder as disease. American Psychologist, 1961, 16, 69-74.

Becker, H. S. Outsiders: Studies in the sociology of deviance. New York: Free Press, 1963.

Bentz, K. & Edgerton, W. The consequences of labeling a person as mentally ill. Social Psychiatry, 1971, 6, 29-33.

Bord, R. Rejection of the mentally ill: Continuities and further developments. Social Problems, 1971, 18, 496-509.

Bordura, D. Recent trends: Deviant behavior and social control. Annals of the American Academy of Political and Social Science, 1967, 149-163.

Brill, M. & Storrow, H. Social class and psychiatric treatment. Archives of General Psychiatry, 1960, 3, 340-344.

Buss, A. Psychopathology. New York: John Wiley, 1966.

California Department of Health. Management Briefs, 1977, 3(2).

Clinard, M. Sociology of deviant behavior. New York: Holt, Rinehart & Winston, 1973.

Cole, N. et al. Some relationships between social class and the practice of dynamic psychotherapy. American Journal of Psychiatry, 1962, 118, 1004-1012.

Cumming, J. & Cumming, E. On the stigma of mental illness. Community Mental Health Journal, 1965, 1, 135-143.

Davis, K. Mental hygiene and the class structure. Psychiatry, 1938, 4, 55-56.

Dollard, J. & Miller, N. Personality and psychotherapy. New York: McGraw Hill, 1950.

Erikson, K. T. Notes on the sociology of deviance. Social Problems, 1962, 9, 65-73.

Erikson, K. Wayward puritans. New York: John Wiley, 1966.

Freeman, H. & Simmons, O. Feelings of stigma among relatives of former mental patients. Social Problems, 1961, 8, 312-331.

Freeman, H. & Simmons, O. Mental patients in the community: Family settings and performance levels. American Sociological Review, 1958, 23, 147-154.

Garfinkel, H. Conditions of successful degradation ceremonies. American Journal of Sociology, 1956, 61, 420-424.

Gibbs, J. Issues in defining deviant behavior. In S. Rober & J. Douglas (Eds.), Theoretical perspectives on deviance. New York: Basic Books, 1972, 39-68.

Goffman, E. Interaction ritual: Essays on face to face behavior. New York: Doubleday, 1967.

Gove, W. & Fain, T. The stigma of mental hospitalization. Archives of General Psychiatry, 1973, 28, 494-500.

Gove, W. The labeling of deviance. New York: John Wiley,

1975.

Gruenberg, E. Mental health in the metropolis: The Midtown Manhattan study. New York: Milbank Fund, 1963.

Grusslin, O. et al. Social class and the mental health movement. Social Problems, 1959, 7, 210-218.

Gurin, G. et al. Americans view their mental health. New York: Basic Books, 1960.

Haas, W. The role of socioeconomic class in examiner bias. In Riessman et al. (Eds.), Mental health of the poor. New York: The Free Press, 1964,

Heidbroder, E. Seven psychologies. New York: Appleton, 1933.

Hunt, R. G. Social class and mental illness: Some implications for clinical theory and practice. American Journal of Psychiatry, 1961, 116, 1065-1077.

Jaco, E. G. The social epidemiology of mental disorders. New York: Russell Sage Foundation, 1960.

Kirk, S. The impact of labeling on rejection of the mentally ill: An experimental study. Journal of Health and Social Behavior, 1974, 15, 108-117.

Klee, G. et al. An ecological analysis of diagnosed mental illness in Baltimore. In Riessman et al. (Eds.), Mental health of the poor. New York: The Free Press, 1964.

Kolb, L. & Dohrenwend, B. Urban challenges to psychiatry: The case history of a response. Boston: Little Brown,

1969.

Kutner, L. The illusion of due process in commitment proceedings. Law Review, 1962, 57, 383-399.

Lemert, E. Human deviance, social problems, and social control. Englewood: Prentice Hall, 1967.

Lemert, E. Social pathology. New York: McGraw-Hill, 1951.

Levine, S. & Scotch, N. Social stress. Chicago: Aldine, 1970.

Leifer, R. In the name of mental health: Social functions of psychiatry. New York: Science House, 1969.

Macoby, E. The choice of variables in the study of socialization. Sociometry, 1961, 24, 357-370.

Mechanic, D. Mental health and social policy. New York: Prentice Hall, 1969.

Mehlman, B. The reliability of psychiatric diagnosis. Journal of Abnormal and Social Psychology, 1952, 647, 577-578.

Milbank Memorial Fund. Causes of mental disorders. New York: Milbank Memorial Fund, 1961.

Myers, J. & Bean, L. A decade later: A follow-up of social class and mental illness. New York: John Wiley, 1968.

Myers, J. K. & Roberts, B. H. Family and class dynamics in mental illness. New York: John Wiley, 1959.

Noyes, A. P. & Kolb, L. E. Modern clinical psychiatry (sixth edition). Philadelphia: Saunders Co., 1963.

NIMH. Mental health statistics series, 69-71. Washington,

D.C.: U.S. Government Printing Office, 1971.

Overall, B. & Aronson, H. Expectations of psychotherapy in patients of lower socioeconomic class. American Journal of Orthopsychiatry, 1963, 33, 421-430.

Phillips, D. Rejection: A possible consequence of seeking help for mental disorders. American Sociological Review, 1963, 28, 963-972.

Riessman, F. et al. (Eds.). Mental health of the poor. New York: The Free Press, 1964.

Rosenhan, D. On being sane in insane places. Science, 1973, 179, 250-258.

Rosenthal, D. & Frank, J. D. The fate of psychiatric clinic outpatients assigned to psychotherapy. Journal of Nervous and Mental Disease, 1958, 127, 330-343.

Sampson, H. The mental hospital and marital family ties. Social Problems, 1961, 9, 141-155.

Sandifer, M. G. Social psychiatry 100 years ago. American Journal of Psychiatry, 1962, 118, 749-750.

Schaffer, L. & Myers, J. Psychotherapy and social stratification. Psychiatry, 1954, 17, 83-93.

Scheff, T. J. The role of the mentally ill and the dynamics of mental disorder: A research framework. Sociometry, 1963, 26, 436-453.

Scheff, T. The societal reaction to deviance: Ascriptive elements in psychiatric screening of mental patients in a Midwestern State. In Spitzer & Denzen (Eds.),

The mental patient. New York: McGraw-Hill, 1968.

Scheff, T. Labeling madness. Englewood Cliffs: Prentice Hall, 1975.

Schroder, D. & Ehrlich, D. Rejection by mental health professionals: A possible consequence of not seeking appropriate help. Journal of Health and Social Behavior, 1968, 9, 222-237.

Schwartz, C., Myers, J., & Astrachan, B. Psychiatric labeling and rehabilitation of the mental patient. Archives of General Psychiatry, 1974, 31, 329-334.

Segal, J. Research in the service of mental health: A report of the research task of NIMH. Rockville, Md.: National Institute of Mental Health, 19

Seyle, H. Stress and disease. Science, 1955, 122, 625-631.

Shostok, A. B. Blue collar life. New York: Random House, 1969.

Spiro, H. Ability of the public to recognize mental illness. Social Psychiatry, 1973, 8, 32-36.

Spitzer, L. & Denzin, A. The mental patient: Studies in the sociology of deviance. New York: McGraw-Hill, 1968.

Srole, L. et al. Mental health in the metropolis: The Midtown study. New York: McGraw-Hill, 1962.

Strauss, A. et al. Psychiatric ideologies and institutions. New York: Free Press, 1964.

Swanson, R. & Spitzer, S. Stigma and the psychiatric pa-

tient career. Journal of Health and Social Behavior, 1970, 11, 44-51.

Szasz, T. The myth of mental illness. New York: Harper and Row, 1974.

Tannenbaum, F. Crime in the community. Boston: Ginn, 1938.

Temerlin, M. Suggestion effects in psychiatric diagnosis. Journal of Nervous and Mental Disease, 1968, 147, 349-353.

Thomas, A. & Sillen, S. Racism and psychiatry. New Jersey: Citadel Press, 1972.

Wolfensberger, W. The principle of normalization in human services. Toronto: National Institute on Mental Retardation, 1972.

Wood, E. Interpersonal aspects of psychiatric hospitalization. In Spitzer & Denzen (Eds.), The mental patient. New York: McGraw-Hill, 1968,

APPENDIX A

Background Information on Region I

The Massachusetts Department of Mental Health has divided the state into seven Regions and forty Areas to decentralize the delivery of services to the mentally retarded. Region I is the westernmost region, serving a (1975) population of about 750,000 in about 2000 square miles. Geographically it is approximately the western third of the state; the major cities are Springfield, Holyoke, Chicopee, and Pittsfield.

Region I is further subdivided into five DMH Areas. They are listed below with their approximate 1975 population.

Berkshire	147,000
Franklin/Hampshire	136,000
Holyoke-Chicopee	156,000
Springfield	216,000
Westfield	100,000

APPENDIX B

Descriptive Data for the State Hospital

Statistics for Fiscal Years: 1971, 1972, 1973, 1974, 1975, 1976

	1971	1972	1973	1974	1975	1976
Total Admissions	1,473	1,333	1,283	1,210	1,148	1,055
Readmissions	562	615	661	649	652	630
Discharged	701	765	630	839	977	824
Visits Confirmed	986	897	950	779	328	294
Transfers	19	10	6	4	2	2
Deaths	110	107	90	69	40	29
Average Daily Census	1,517	1,291	1,065	919	691	536
Average Admissions per Month	123	111	107	100	95	88
Average Number of Patients on Visit	990	739	505	293	159	179
Census-Beginning of Fiscal Year	1,640	1,424	1,132	976	838	598
Census-Ending of Fiscal Year	1,424	1,132	976	838	592	492
Inpatient Days for Fiscal Year	553,850	472,667	388,889	335,403	252,508	196,135
Total Number of Male Patients Admitted	852	755	695	633	616	609
Total Number of Female Patients Admitted	621	578	588	577	532	446
Age on Admission--under 20	139	108	116	107	109	71
Age on Admission--20-29	342	328	332	347	338	336
Age on Admission--30-39	284	238	227	222	227	210
Age on Admission--40-49	281	253	221	206	197	165
Age on Admission--50-59	211	189	185	155	132	133
Age on Admission--60-69	107	124	106	96	79	97
Age on Admission--70-79	61	56	48	45	45	28
Age on Admission--80-89	46	29	42	27	17	14
Age on Admission--90-99	2	6	6	3	4	1
Age on Admission--100 and over	-	1	-	-	-	-
Age on Admission--Unknown	-	1	-	2	-	-

ISSION M*

FIRST | RE | U | C | D FORM

2 FACILITY NAME | 3 FAC CODE | 4a WARD UNIT | 4b STATU | 5 CONF

6. CASE NUMBER OR ID NUMBER | 7. SEX | 8. AGE | 9. DATE OF BIRTH month-day-year | 10. LEGAL STATUS (inpatients only) | 11 LEGAL STATUS DATE month day year | 12 ADM SION DATE month day year

ME last | first | middle initial | maiden name | 14a CATCH AREA

UAL ADDRESS no. and street or rd. | city, town or village | state | zip code | county | 14c ADDRESS CODE

IAL SECURITY NO. | 16. OCCUPATION | 17. NAME AND LOCATION OF LAST PSYCHIATRIC OR RETARDATION FACILITY OR SERVICE

MARK ONLY ONE CHOICE EXCEPT AS SPECIFIED—USE ONLY NO. 2 PENCIL

SECUTIVE NUMBER

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

ON CODE
1st Re U C D Form

20. EMERGENCY Yes No

RAN Yes No

22. CITIZENSHIP U. S. Other

RONMENT
Form City/Village Rural Non-form Unknown

GION
Protestont Roman Catholic Jewish
None Other Unknown

IC GROUP
White Negro American Indion Puerto Rican
Oriental Other Unknown (1) See Instructions

ENT MARITAL STATUS
Never Married Married Remarried Separoted
Divorced/Annulled Widowed Unknown

SEHOLD COMPOSITION (Mark ALL which apply)
Lives Alone With Children With Others
With Spouse With Siblings In Institution
With Parents With Other Relatives Unknown

ATION—HIGHEST GRADE COMPLETED
UNGRADED 1 2 3 4 5 6 7 8 9
0 11 12 VOC OR TECH BUS COLL 1 COLL 2 COLL. 3 COLL 4 GRAD. SCHOOL UNKNOWN

LY FAMILY INCOME (Averoge Net Dollors)
UNDER BELOW 50 50-99 100-149 150-199 200-299 300 AND OVER UNKNOWN

OF INDIVIDUALS ON FAMILY INCOME
1 2 3 4 5 6 7 8 9 AND OVER UNKNOWN

LEM APPRAISAL (Mark ALL which apply)
Consider 2 wks. preceding interview

SICAL FUNCTION TURBANCE
Sleep Problems
Eating Problems
Enuresis, Soiling
Seizures, Convulsions
Speech Articulation Problems
Other Physical Problems

LLECTUAL ELOPMENT
Inadequate

IAL RELATIONS TURBANCE
With Child
With Mate, Spouse
With Other Family
With Other People

SOCIAL PERFORMANCE DISTURBANCE
Job
School
Housekeeping

OTHER SIGNS AND SYMPTOMS
Suicidal Thoughts
Suicidol Acts, Gestures
Anxiety, Fears, Phobias
Obsessions, Compulsions
Depressed Mood, Inferiority
Somotic Concerns, Hypochondriosis
Sociol Withdrawal, Isolation
Dependency, Clinging
Grondiosity

Suspicion, Persecution
Delusions
Hollucinotions
Anger, Belligerence, Negotivism
Assoultive Acts
Alcohol Abuse
Sexual Problems
Norcotics, Other Drugs
Anti-Sociol Attitudes, Acts
Agitotion, Hyperoctivity
Disorientotion, Impaired Memory
Speech Disorg., Incoherence
Slowed up, Lack of Emotion
Inoppropriote Affect, Appearonce, Behovior
Daily Routine, Leisure Time, Impair.

30. FACILITY CODE

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

31. SOURCE OF REFERRAL
Self
Fomily or Friend
Clergy
School
Police (Excluding Court or Correction Agency)
Private Psychiotrist
Other Private Physicion
Mental Health Center
Mental Hospital
General Hosp.–Psychiatric Unit
General Hosp.–Other Unit
Nursing Home
Psychiatric Clinic
Other Psychiatric Facility
Institution for Retarded
Other Retardation Facility
Court or Correction Agency
Public Health or Welfare Agency
Division of Vocational Rehabilitation
Voluntary Agency
Other

32. TIME SINCE LAST PSYCHIATRIC OR RETARDATION SERVICE
NO PRIOR SERVICE | WITHIN SAME DAY | WITHIN 7 DAYS | WITHIN 30 DAYS | WITHIN 6 MOS | WITHIN 1 YEAR | OVER 1 YEAR | LAST SERVICE WAS— IN PATIENT | OTHER

CODE FOR LAST FACILITY OR SERVICE

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

0 1 2 3 4 | 5 6 7 8 9

33. PRIOR PSYCHIATRIC OR RETARDATION FACILITY OR SERVICE (Mark ALL which apply)
NONE UNKNOWN

INPATIENT
This Facility
Mental Hospital
Mental Health Center
General Hospital
V. A. Hospital
Institution for Retarded
Other

ALL OTHER
This Facility
Mental Health Center
Nursing Home
Residential Treatment Center
Partial Hosp.
Psychiatric Clinic
Other Psychiatric Facility
Private Psychiatrist
Other Private Therapist
Retardation Facility
School, Special Class
Hostel or Halfway House
Penal Institution
Other

35. OVERALL SEVERITY OF CONDITION
NOT ILL | SLIGHT | MILD | MODERATE | SEVERE

36. PROBLEM DURATION LESS THAN
WEEK | MONTH | 1 YEAR | 2 YEARS | 2 YEARS & OVER

37. WRITE PSYCHIATRIC DIAGNOSIS OR IMPRESSION (Include Code, Use APA Manual II, 196B)

COMPLETED BY DATE

CHANGE IN STATUS

PATIENT NAME

E CONSECUTIVE NUMBER

FACILITY CODE

DATE OF CHANGE

MONTH

YEAR

DAY

ON CODE — NEW — CORRECT — DELETE FORM — ONLY

NGE IN STATUS — COMPLETE SECTIONS AS APPROPRIATE

OME VISIT TEMPORARY LEAVE UP TO 7 DAYS — C

AVE FOR SPECIFIED PERIOD OVER 7 DAYS — C I

CONVALESCENT CARE TRIAL VISIT INDEFINITE PERIOD — D I

D-I

STER FAMILY CARE — D I

AVE WITHOUT CONSENT

CAPE

MPORARY TRANSFER TO OUTSIDE FACILITY — D F H I

TURN FROM ANY STATUS ABOVE — B

PMANENT TRANSFER TO OUTSIDE FACILITY — D F H I

SCHARGE — D I

ATH

W WARD ASSIGNMENT — A B D I

NUMBER BEFORE CHANGE

NUMBER AFTER CHANGE

TED TIME IF LEAVE IS TEMPORARY — DAYS — MONTHS

DE FACILITY CODE

ARE MEDICAID ELIGIBILITY — DAYS — TITLE 18A — TITLE 18B — TITLE 19

CHANGE IN TYPE OF CARE (MARK ALL WHICH APPLY)

	BEGIN	DISCONTINUE
DAY CARE		
NIGHT CARE		
PARTIAL CARE - OTHER OR UNSPECIFIED		
FULL TIME CARE		
OUTPATIENT		
(1)		
(2)		
(3)		

CONDITION ON RELEASE — E

RECOVERED	UNIMPROVED	WITHOUT MENTAL DISORDER
MUCH IMPROVED	WORSE	UNDETERMINED
IMPROVED		

REASON FOR RELEASE — F

NO FURTHER CARE BY THIS FACILITY INDICATED	CAPACITY TRANSFER	OUTPATIENT WITHDREW FACILITY NOT NOTIFIED
TYPE SERVICE UNAVAILABLE THIS FACILITY	DISCHARGE AGAINST MEDICAL ADVICE	FACILITY NOTIFIED PATIENT MOVED
	OTHER	FACILITY NOTIFIED OTHER

RELEASE WITHOUT REFERRAL — G

NO FURTHER CARE INDICATED	FURTHER CARE INDICATED BUT UNAVAILABLE	PATIENT UNRESPONSIVE TO REFERRAL

RELEASE WITH REFERRAL (MARK ALL WHICH APPLY) — H

MENTAL HOSPITAL	NURSING HOME	PRIVATE PSYCHIATRIST
MENTAL HEALTH CENTER	RESIDENTIAL TREATMENT CENTER	OTHER PRIVATE PHYSICIAN
GENERAL HOSPITAL PSYCHIATRIC UNIT	PARTIAL HOSPITAL, DAY	SCHOOL, SPECIAL CLASS
GENERAL HOSPITAL OTHER UNIT	PARTIAL HOSPITAL, OTHER	COURT, OR CORRECTION AGENCY
VA HOSPITAL	PSYCHIATRIC CLINIC	PUBLIC HEALTH OR WELFARE AGENCY
INSTITUTION FOR RETARDED	DAY TRAINING CENTER	VOLUNTARY AGENCY
OTHER RETARDATION FACILITY	SHELTERED WORKSHOP	CLERGY
HOSTEL HALFWAY HOUSE	VOCATIONAL TRAINING	OTHER

DESTINATION HOUSEHOLD (MARK ALL WHICH APPLY) — I

		WITH OTHER RELATIVES
RETURN TO USUAL HOUSEHOLD	WITH CHILDREN	WITH OTHERS
WILL LIVE ALONE	WITH SIBLINGS	INSTITUTION
WITH SPOUSE	WITH PARENTS	UNKNOWN

APPENDIX E

H-C Unit Admissions and Discharge Procedure

1) THE CRITERIA FOR ADMISSION:

In theory, in order to be admitted to the State Hospital, one must (a) voluntarily admit oneself, (b) be psychotic and (c) be a danger to oneself or others. The State Hospital does not treat drug addicts or alcoholics. However, patients are admitted under various circumstances and hence fall into different categories.

First, there are the VOLUNTARY admissions: those who come in on their own, or are sent by their families and/or doctors. They must fill out a form entitled, "Application for Care on a Conditional Voluntary Basis" and referred to as a Section 10-11. Section 10-11 patients may leave at any time if they notify the Superintendent with a written request three (3) days beforehand. However, if it is the opinion of the doctors on the staff that the patient is not yet ready to leave, the hospital can and will petition the district court for further retention. In order for a patient to be kept voluntarily, a qualified physician must state (and provide evidence to support the statement) that "the patient requires hospitalization so as to avoid the likelihood of serious harm (to himself or to others) by reason of mental illness."

A Second Class of patients are those admitted under the "Application for Temporary Hospitalization"--referred to as a Section 12. Patients under this section are admitted on an involuntary basis for a period of not more than ten (10) days. This application must be signed by a qualified physician, and as noted above, the physician must support his claim that if the patient is not hospitalized, there would be a "likelihood" of serious harm (to the patient or to others)." ALL patients admitted under Section 12 have the right to a voluntary admission. That is, they have the right to sign themselves in as a voluntary (Section 10-11) patient.

The Third Class of patients admitted to the State Hospital are those who are sent by the courts. This class consists of those who have been apprehended by the police and brought before a court on charges such as

breaking and entering, disturbing the peace, etc . The judge or court officials fill out a form referred to as a Section 15(b) and entitled, "Order of Commitment of a Defendant for Observation." The court states that the defendant is not competent to stand trial and he is committed for observation and testing for a period not to exceed twenty (20) days.

2) THE METHOD OF EVALUATING COURT CASES:

In general, court cases are evaluated in a manner very similar to the 10-11 and 12 cases. In all three categories, a "team approach" is stressed. A team, which consists of the M.D.'s, nurses, psychologists, and social workers in the Unit, undertakes a psychiatric evaluation of the patient. The resources drawn upon include: a social history, psychological testing, observation, and an evaluative interview by the team.

The opinions of all concerned are considered and attempts are made to be as cautious and as thorough as possible. However, court cases are differentiated from the other cases in that the Clinical Director of Psychiatry and/or the Assistant (Medical) Superintendent are involved in the evaluative work. These doctors may be consulted with concerning the other cases, but they are always involved in the court cases.

3) THE METHOD USED TO INFORM PATIENTS OF THEIR RIGHT TO A VOLUNTARY ADMISSION:

As noted above, all Section 12 patients are informed of their right to a voluntary admission. This is done by the nursing staff on admission. Each patient is presented with a 10-11 paper to read and (if s/he desires to) sign. If the patient is not coherent during admission, s/he is informed of his/her rights when coherent. Furthermore, if the incoming patient is a veteran, s/he is advised of his/her right to be admitted into the Veteran's Administration Hospital. Court cases (15(b)), however, are NOT allowed to sign a voluntary admission form.

4) THE AVERAGE LENGTH OF STAY OF PATIENTS IN EACH CATEGORY:

On the following page a chart is provided which lists, by category (10-11, 12, 15(b)), the number of patients discharged in the past six (6) months from Unit III.

As noted in the chart, most of the patients discharged (39 out of 59) have been Section 10-11's. However, the average length of stay for the 10-11 patients is not a very helpful figure. The total average length of stay for 10-11 patients is 870 days. Yet, out of the 39 10-11 patients discharged, 23 (or 60%) of them stayed for less than 20 days, and five (5) stayed for over 1,000 days. The 1,000+ days patients were, in general, geriatric patients who were finally referred to nursing and/or rest homes.

5) THE CRITERIA USED FOR RECOMMENDING THE DISCHARGE OF PATIENTS IN THE VARIOUS CATEGORIES:

As noted in (2) above, each patient is evaluated by a team. Again, the basic criterion for discharge is that the team believes the patient to be able to manage on the outside without harming him/herself or others. Other considerations involve: his/her family situation, his/her friends, and his/her relatives, and his/her need for shelter and employment. However, it must be stressed that the patient is not suddenly allowed to leave. With respect to the court cases, of course, if the patient is believed to be competent to stand trial, s/he is released to the court. But, in most other cases, the patient is first gradually given more and more freedom--and his/her progress is evaluated at each stage. For example, many patients are first given weekend passes, i.e., allowed to spend the weekend at home with their families. They are also given "grounds," i.e. allowed to leave the ward, but not the hospital grounds, during the day or for a fixed period of time during the day.

APPENDIX F

DIAGNOSTIC CATEGORIES USED FOR THOSE ADMITTED

Diagnostic Category	Number
Involutional Melancholia	4
Adjustment reaction to late life	1
Adjustment reaction to adolescence	3
Schizophrenia, chronic undifferentiated	5
Brain trauma	3
Passive aggressive personality	1
Inadequate personality	1
Psychosis	10
Marital maladjustment	3
Schizophrenic paranoid type	3
Drug dependence	3
Habitual excessive drinking	4
Involutional paranoia	2
Explosive personality	2
Schizophrenic catatonic type	2
Adjustment reaction of adult life	3
Hysterical personality	2
Depressive neurosis	13
Acute schizophrenic episode	9
Schizophrenic--hebephrenic type	1
Alcoholism	4

APPENDIX G

State Hospital Recidivism (All Inclusive)

	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Totals
75/76 Total Admissions	99	86	98	109	80	89	77	72	97	72	87	89	1055
Patients Admitted with Previous Admis.	64	47	58	67	45	55	41	39	65	41	51	52	625 59.2%
UNIT I--Patient Admissions	17	12	9	11	12	11	10	12	13	6	12	10	135
Readmissions	14	7	6	6	8	7	7	9	10	3	4	6	87 64.4%
UNIT II--Patient Admissions	23	18	24	20	23	7	14	16	22	16	16	26	225
Readmissions	11	11	14	14	11	5	5	7	14	10	8	15	125 55.5%
UNIT III--Patient Admissions	18	23	15	23	11	31	17	15	18	26	19	16	232
Readmissions	11	14	8	15	7	21	13	10	12	15	15	11	152 69.8%
UNIT IV--Patient Admissions	29	26	37	39	28	34	26	19	28	22	33	27	348
Readmissions	21	10	22	24	15	19	11	10	17	11	21	13	194 55.7%
UNIT V--Patient Admissions	12	7	13	16	6	6	10	10	16	2	7	10	115
Readmissions	7	5	8	8	4	3	5	3	12	2	3	7	67 38.2%

APPENDIX H

California Department of Health Management Briefs

Volume 3 No. 2

March 23, 1977

One of the easiest, but most humiliating ways to subject human beings to ridicule is through the use of belittling words. This is true whether the offending phrase is intended or merely spoken in haste or without thought.

While some labelling practices in the field of medical practice do serve a functional need, people in a bureaucracy as large as the State Health Department which has responsibility for thousands of persons with significant medical needs must constantly strive to treat all persons with dignity and not lapse into the use of stereotyped expressions or characterizations of people, whatever their problems or disabilities. All human beings should be treated with dignity and this includes the words chosen to describe or address them.

The purpose of the Policy Statement Regarding Stigmatizing and Excessive Labelling of Persons with Developmental Special Needs is to sensitize State Health Department members to the need for humane treatment of all persons, in word as well as in deed.

* * * * * *

POLICY STATEMENT REGARDING STIGMATIZING AND EXCESSIVE LABELLING OF PERSONS WITH DEVELOPMENTAL SPECIAL NEEDS

The field of developmental services has grown progressively more sensitive and responsive to the unnecessary, excessive and stigmatizing use of diagnostic and descriptive labels associated with its clients.

Such labelling practices have a long tradition whose roots come from both the evolving sciences of human development and perpetuated prejudices, historically held against people who are significantly different.

Labelling has limited helpful uses. Ideally, it must assist in preventing, treating and overcoming various human debilitating conditions and situations. Labelling has also focussed the channeling of resources and organizations to

improve the condition of minority groups of all kinds. It has served to aid in setting priorities in the face of finite resources given our wide social needs.

Nevertheless, labelling invariably draws negative attention and stigma upon the individual or group concerned. It gradually supplants the unique identity and totality of a person with a stereotype that emphasizes the need, problem or liability of an individual as the main aspect of that person or group. It does injury to a person's social value, status, societal mobility and freedom.

Labelling carries with it a constant danger of being abused for professional and bureaucratic convenience to the detriment of people with special needs.

California has adopted the principles of normalization in human services, which underscores the rigorous approach of serving people in such a way as to avoid stigma and establish program quality criteria as a minimum above which services must be aimed. Eliminating unnecessary and injurious labelling is basic to normalization.

It is therefore the policy of this administration to clear away all archaic, stigmatizing, dehumanizing and syntactically incorrect usage of labels and replace these with appropriate socially valued references that emphasize the humanity and individuality of our consumer constituency whenever possible.

The following are typical frequent instances of such excesses and abuses:

1. Equating a person with his/her deviancy so that the deviancy becomes the person (e.g., an "MR", a "retardate", "TMR's" or "EMR's", a "DD", an "autistic", "epileptic", "schizophrenics", a "spastic", "CP's", etc., instead of "persons who have mental retardation" or "who are labelled mentally retarded", or "persons with developmental special needs").

2. Depersonalization or literally dehumanizing an individual via a label to a status equivalent to an animal, vegetable, or object (e.g., referral to persons by number, as objects, items, clinical material, low-grades, vegetables, etc.).

3. Application of any diagnostic, descriptive, or classification term that is archaic or racist, (e.g., "mongoloid idiot", "monogoloid", "imbicile", "moron", "lunatic", "borderline", "higher function-

ing, lower functioning", etc.).

4. Unnecessary application of labels that denote a devalued status, (e.g., using last names without titles--"Jones" rather than "Ms. Jones") or age inappropriate and degrading labels and titles (e.g., "adult child", "Johnny" instead of "John" or "Mr. Smith" for an adult being spoken of or introduced to others).

5. Repeated unnecessary use of a label when initial identification or the context makes such repetition unnecessary.

Any labelling that must be used should immediately lend itself to identifying rational, particular, helping services interventions, modern treatment modalities or needs.

The archaic equation still heard that "a mongoloid baby should be put away and forgotten" represents a compound insult that must be exposed and ended once and for all. The equation that a person with a low IQ score is "beyond help and will never go to school, be employable, or go to college" denies the flexibility, breadth of options, power of educational technology and normalization principles that have evolved in our service system design today and its continued improvement tomorrow.

Such equations blunt our thinking, confuse our technology, and humiliate all of us.

In sum, every effort must be explored and exhausted to clear up our example, practices, and literature regarding such stigmatizing labelling to establish positive and socially valued images and identities for people with special needs. Given the deeply ingrained tradition of substituting labels and diagnoses for people's identity will require considerable effort, sensitivity and affirmative spirit to redo and undo what has become secondhand and unconscious for most of society.

* * * * * *